

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

PRINTED: 12/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/04/2013
NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE FLATWOODS, KY 41139		
(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 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00021002 was initiated on 12/03/13 and concluded on 12/04/13. KY#00021002 was substantiated with a related deficiency cited at a Scope and Severity of "D".	F 000	Oakmont Manor does not believe and does not admit that any deficiencies existed, either before, during or after the survey. Oakmont Manor reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings.		
F 226 SS=D	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, interview and review of the facility policy, it was determined the facility failed to implement written policy related to reporting verbal abuse; and, failed to implement written policy on investigating abuse by not interviewing all residents the alleged perpetrator had provided care for. Additionally, staff failed to implement written policy by not immediately reporting witnessed alleged verbal abuse to facility Administration as per policy for two (2) of three (3) sampled residents (Resident #1 and Resident #2). This resulted in two (2) incidents of alleged abuse by State Registered Nursing Assistant (SRNA) #1 to Resident #1 and Resident #2. The findings include: Review of the facility "Abuse" policies dated 08/01/13, revealed the goal of the facility was to	F 226	This plan of correction does not constitute any admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Oakmont Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver or any potentially applicable peer review, quality assurance or self-critical examination privileges which Oakmont Manor does not waive, and administrative, civil or criminal claim, action or proceeding. Oakmont Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care of residents.		

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JAN 31 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Shanna Carter ADMINISTRATOR TITLE
1-31-14 (X6) DATE

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

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F 226	<p>Continued From page 1</p> <p>maintain an abuse free environment. Further review revealed anyone observing an incident of resident abuse or suspecting resident abuse were to report this information immediately to the Administrator or his/her designee. All reports of resident abuse were to be promptly and thoroughly investigated by facility management. Continued review revealed the person conducting the investigation would interview other residents to whom the accused employee provided care or services. In addition, review revealed residents would be protected from any harm during the investigation; and, employees accused of alleged abuse would be suspended immediately until the findings of the investigation were reviewed by the Administrator.</p> <p>Review of Resident #1's record revealed the facility admitted the resident on 10/16/11, with diagnoses which included Anxiety, Depression and Dementia. Continued review of Resident #1's record revealed on 09/28/13 the facility had assessed the resident to be cognitively impaired with short and long term memory deficits.</p> <p>Review of Resident #2's record revealed the facility admitted the resident on 04/21/07, with diagnoses which included Anxiety, Depression and Dementia with agitated features. Continued review of Resident's #2's record revealed on 10/21/13 the facility assessed the resident to be severely cognitively impaired.</p> <p>Review of the facility provided list of residents the alleged perpetrator, State Registered Nurse Aide (SRNA) #1 had cared for, revealed there were a total of ten (10) residents he cared for on 11/09/13 and 11/10/13. Review of the facility's "Initial Report" dated 11/10/13, revealed SRNA #1</p>	F 226	<p>It is and was on the day of survey the policy of Oakmont Manor to implement policies and procedures that prohibit mistreatment, neglect, abuse, and misappropriation of resident property. Oakmont Manor did complete an investigation into this identified incident as it was self-reported; however, the facility is held to a strict liability standard related to the actions of the employees.</p> <p>Resident #1 and #2 had no adverse effect related to the identified practice as weekend supervisor (RN) And DON interviewed residents #1 and #2 on 11/10/13. SRNA #1 was suspended at the time that the incident was reported on 11/10/13.</p> <p>There was no adverse effect to any other resident that SRNA #1 provided care to as weekend supervisor and charge nurse made rounds and observed for sign and symptoms of distress or increased behaviors on 11/10/13 following the report of the incident.</p>		

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F 226 Continued From page 2
made inappropriate comments to Resident #2 and then to Resident #1 on 11/09/13. Continued review of the "Initial Report" revealed SRNA #1 was witnessed to tell Resident #1 he might "only have a one (1) inch peter but" knew how to "use it". Further review revealed SRNA #1 was witnessed to state to Resident #2 "get that big cherry ass over there".

Review of SRNA #1's time card revealed the SRNA worked from 1:58 PM until 10:27 PM on 11/09/13; and, clocked in again to work on 11/10/13 at 5:59 AM and clocked out at 5:09 PM.

Personnel record review revealed a document titled, "Reporting Resident Abuse" which indicated staff were to report resident abuse immediately to a supervisor, Director of Nursing (DON) or Administrator. Continued review of this document revealed it was the right of facility residents to be free from physical and verbal abuse. Further review of the document revealed, "never wait until your shift is over or until the next day" to report possible abuse.

Interview with SRNA #1 on 12/03/13 at 3:25 PM, revealed he had made a comment to Resident #2 on 11/09/13 about the cherry tattoo on his/her "bottom"; however, he denied telling the resident he/she better get his/her "fat cherry ass" to the toilet or "over there". SRNA #1 indicated he had not been verbally abusive to Resident #1. Continued interview with SRNA #1 revealed he had made a comment to Resident #1 on 11/09/13. SRNA #1 stated he did not recall his exact words to the resident; but denied stating he had a one (1) inch "peter" and knew how to use it. He stated he worked "all day" on 11/10/13. Review of State Registered Nursing Assltant

F 226 All staff were educated on 11/10/13 and 11/11/13 by DON and/or charge nurse regarding the policy on reporting abuse, neglect, mistreatment and misappropriation of resident property. As part of the ongoing Quality Assurance Program the QA nurse periodically queries staff to ensure that they understand the policies and procedures regarding abuse, neglect and misappropriation. New hires take a post-test on abuse, neglect and misappropriation at the time of orientation.

As part of the facilities ongoing Quality Assurance Program, the Administrator and/or DON will review all incidents of alleged abuse, neglect, or misappropriation to ensure that policies and procedures were followed and report any reportable incidents to OIG and other appropriate agencies. The QA nurse will query 10 employees per month for six months to ensure their understanding of abuse, neglect and misappropriation. Results of any incidents will be reported to the Quality Assurance Committee which meets monthly and the meeting is attended by the medical director, Administrator, DON, ADON, QA nurse, pharmacist, social worker, environmental Supervisor, bookkeeper. A QA meeting was held on 11/27/13 to discuss compliance with abuse policies and procedures.

12/19/13

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F 226	<p>Continued From page 3</p> <p>(SRNA) #1 personnel record revealed he had signed the "Reporting Resident Abuse" form on 08/27/13, his date of hire.</p> <p>Interview with SRNA #2 on 12/03/13 at 4:10 PM, revealed she had witnessed SRNA #1 tell Resident #2 to "scoot" his/her "cherry ass" on 11/09/13. She stated she did not report hearing SRNA #1 say this to Resident #2 immediately. SRNA #2 stated she reported SRNA #1's comments to Resident #2 to Licensed Practical Nurse (LPN) #1 on 11/10/13 "about 3:00 PM". Review of SRNA #2's personnel record revealed she had signed the "Reporting Resident Abuse" form on 01/03/12, her date of hire.</p> <p>Interview with SRNA #5 on 12/03/13 at 5:50 PM, revealed she witnessed the comments SRNA #1 made to Resident #1 on 11/09/13; but, did not report this immediately to her supervisor. SRNA #5 stated she was "shocked" by SRNA #1's comments to Resident #1; however, SRNA #1's comments did not register as possible abuse until she had thought about it after work on 11/09/13. She indicated she reported SRNA #1's comments to Resident #1 to LPN #1 on 11/10/13 after she arrived at work. Review of SRNA #5's personnel record revealed she had signed the "Reporting Resident Abuse" form on 06/19/13, her date of hire.</p> <p>Interview with LPN #1 on 12/03/13 at 5:55 PM, revealed SRNA #2 and SRNA #5 reported SRNA's comments to Resident #1 and Resident #2 on 11/10/13 between 4:00 PM and 5:00 PM. LPN #1 stated she reported this information to Registered Nurse (RN) #1 after she obtained statements from SRNA #2 and SRNA #5. According to LPN #1, at the time she reported the information to RN</p>	F 226		

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F 226	<p>Continued From page 4</p> <p>#1, SRNA #1 was passing trays and the RN stayed with him. Additional interview with LPN #1 on 12/04/13 at 1:50 PM, revealed SRNA #2 and SRNA #5 should have reported SRNA #1's inappropriate comments to the residents on 11/09/13, when the comments were witnessed. LPN #1 stated SRNA #1 should have been immediately removed from the facility as per policy, and, the incidents reported immediately to the DON and Administrator.</p> <p>Interview with Registered Nurse #1 on 12/04/13 at 9:10 AM, revealed on 11/10/13 sometime around dinner, LPN #1 had made her aware of SRNA #1's comments to Residents #1 and #2. She stated SRNA #1 admitted to making inappropriate comments to Resident #1 and Resident #2; and, she indicated she informed him this was abuse. RN #1 stated SRNA #1, SRNA #2 and SRNA #5 were sent home on 11/10/13 after she was made aware of the alleged abuse. RN #1 stated she talked to Resident #1 and Resident #2; however, did not interview other residents SRNA #1 had cared as per facility policy to ensure no further alleged abuse had occurred. She indicated she "probably" should have interviewed other residents. Additional interview with RN #1 on 12/04/13 at 1:59 PM, revealed SRNA #2 and SRNA #5 should have immediately reported the incidents they had witnessed as per facility policy.</p> <p>Interview with the DON on 12/04/13 at 11:25 AM, revealed the incidents witnessed by SRNA #2 and SRNA #5 on 11/09/13 were not reported to her until 11/10/13. She stated Resident #1 and Resident #2 were interviewed; however, only Resident #2's roommate was interviewed.</p> <p>Further interview with the DON on 12/04/13 at</p>	F 226		
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F 226	Continued From page 5 2:45 PM, revealed the facility policy stated to report abuse immediately and SRNA #2 and SRNA #5 should have reported the incidents when witnessed on 11/09/13. The DON stated SRNA #1 should have been immediately removed from resident care and suspended on 11/09/13. She stated if this had been done SRNA #1 would not have been allowed to work for ten and a half hours on 11/10/13. Interview with the Administrator on 12/04/13 at 2:50 PM, revealed the incidents were reported to her on 11/10/13; however should have been reported on 11/09/13 after SRNA #2 and SRNA #5 witnessed them. The Administrator indicated Resident #1 and Resident #2 had been interviewed and observed for behavioral changes. She stated other residents under SRNA #1's care on 11/09/13 and 11/10/13 were not interviewed as she didn't "think" it would change the outcome. The Administrator stated she felt the facility had performed a thorough investigation.	F 226			