

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

PRINTED: 01/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185346</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 01/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERMITAGE CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1614 PARRISH AVE, WEST OWENSBORO, KY 42301</b>		
(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  Based on implementation of the acceptable POC, the facility was deemed to be in compliance, 12/29/13 as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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

PRINTED: 01/06/2014  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/17/2013
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NAME OF PROVIDER OR SUPPLIER  HERMITAGE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301
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F 000	INITIAL COMMENTS	F 000		
F.226 SS=D	<p>An abbreviated survey investigating #KY21070 was conducted on 12/16/13 through 12/17/13 to determine the facility's compliance with Federal requirements. #KY21070 was unsubstantiated with an unrelated deficiency cited.</p> <p>483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility's policy and procedure review it was determined the facility failed to report and investigate the cause of an injury of unknown origin for one (1) of three (3) sampled residents (Resident #2). The facility identified a bruise to Resident #2's left outer elbow during a skin assessment and failed to report the injury of unknown origin or investigate to determine the cause.</p> <p>The findings include: Review of the facility's policy and procedure titled, "INCIDENT REPORTING", dated 12/2010, revealed "An incident report to be completed for falls, bruises, and skin tears of known or unknown origin." Record review revealed the facility admitted</p>	F 226	<p>Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility 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 of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <ol style="list-style-type: none"> <li>1. Resident #2 was assessed by Director of Nursing and Assistant Director of Nursing on 12/17/13 and was noted to have discoloration to left outer elbow. No other residents were affected by the alleged deficient practice.</li> <li>2. All other resident's skin was assessed by Director of Nursing, Assistant Directors of Nursing and Restorative Nurse Manager on 12/17/13 and 12/18/13 to ensure no other residents were affected by the alleged deficient practice. Resident's were interviewed by Director of Nursing, Assistant</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Bel</i> Administrator	TITLE  Administrator	(X6) DATE  1/28/2014
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F 226	<p>Continued From page 1</p> <p>Resident #2 on 07/31/12 with diagnoses which included Venous Stasis Ulcers (legs), Hypertension, Osteoarthritis, Dementia, Adult Failure to Thrive, and Anemia.</p> <p>Observation of the resident, on 12/17/13 at 8:45 AM, revealed a frail lady sitting in the dining room eating breakfast. He/She would only answer "yes" to a question related to breakfast. Additionally, at 11:15 AM, an observation of a head to toe skin assessment was completed and there was a bruise of unknown origin identified by the nurse completing the assessment. Resident #2 was unable to voice how the bruise occurred.</p> <p>Review of the Certified Nursing Assistant (CNA) Skin Alert Sheet, dated 12/16/13 on 7A-7P shift revealed an old bruise was documented to the left elbow area.</p> <p>Interview with CNA #1, on 12/17/13 at 3:30 PM, revealed he had identified the bruise on Resident #1's left elbow and wrote it on the CNA care tracker form (body audit sheet). Additionally, he stated he informed the charge nurse of the bruise after he finished showering the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/17/13 at 3:42 PM, revealed CNA #1 had informed her of the bruise but had marked it as an old bruise. She stated she assessed the bruise and thought it was a bruise that had already been identified. Additional interview revealed even though she assumed the bruise was old she should have started an investigation because the resident was not able to report how the bruise occurred.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 226	<p>Director of Nursing and Social Services Director on 12/17/13 and 12/18/13 regarding abuse and neglect including the care they receive from facility staff with no negative findings.</p> <p>3. Staff was in-serviced during the week of 12/17/13 by Staff Development Coordinator on facility incident reporting policy to include immediate assessment of resident upon identification of change in condition in resident's skin. State Registered Nurse Aides were in-serviced that in addition to written documentation of new skin areas, must also verbally communicate information to the Charge Nurse. Licensed Nursing Staff were in-serviced to review daily the State Registered Nurse Aides Care Alert Sheets to ensure all new identified areas have been reported to the Charge Nurse. Charge Nurses were also in-serviced to immediately begin investigation as it relates to new skin areas identified through the written documentation on the State Registered Nurse Aide Care Alert Sheet and those verbally communicated from the State Registered Nurse Aides to the Charge Nurse. Director of Nursing met with the Charge Nurse of Resident #2 on 12/17/13 to re-educate on above stated policies. A written consultation was issued on failure to follow policy to the Charge Nurse responsible.</p> <p>4. Assistant Directors of Nursing, Staff Development Coordinator, Admission Nurse, Medical Records Director, Medical Records Assistant and Restorative Nurse Manager will review skin assessments weekly to ensure all</p>		

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F 226	Continued From page 2 12/17/13 at 3:25 PM, revealed she interviewed Resident #2 concerning the bruise and was told by the resident it probably occurred from bumping his/her arm on the bed. Additionally she revealed LPN #1 should have started an investigation, made the appropriate notifications, and put interventions in place to prevent further injury.  Interview with the Administrator, on 12/17/13 at 4:41 PM, revealed he expected the charge nurse on duty to start an investigation immediately and make appropriate notifications as well.	F 226	altered skin integrity have been documented, investigated and root cause analysis identified. Assistant Directors of Nursing, Staff Development Coordinator, Admission Nurse, Medical Records Director, Medical Records Assistant and Restorative Nurse Manager will report findings to Director of Nursing weekly for proper follow up. Director of Nursing will review skin assessment findings and issue educational referrals to Staff Development Coordinator for 1:1 education with nurses identified as needing "investigation and root cause analysis" educational needs. Director of Nursing will report findings monthly to Quality Assurance team for 3 months for recommendations and follow up. 5. Corrective Action Date: 12/29/2013	12/24/13	