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

PRINTED: 10/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		C 09/20/2012
NAME OF PROVIDER OR SUPPLIER: BOWLING GREEN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1561 NEWTON AVE, BOWLING GREEN, KY 42104	

RECEIVED OCT 2012

(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 (KY #19073) was conducted on 09/19/12 through 09/20/12 to determine the facility's compliance with Federal requirements. KY #19073 was unsubstantiated with deficiencies cited.	F 000		
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	F225 – INVESTIGATE/REPORT/ ALLEGATIONS/ INDIVIDUALS 1. The allegation for resident #1 was reported to OIG by the Administrator on 9/17/12 and an investigation was completed by OIG on 9/20/12 and by the facility on 9/21/12. 2. A review of all of the resident concerns made since our last annual survey will be completed by the Administrator by 10/26/12 to ensure proper notification per facility policy. Interviews with residents and staff will be completed by the Administrator and/or Director of Nursing to determine if there are any other allegations that have not been reported timely. Any deficient practices identified will be addressed immediately. 3. LPN's #1 and #2 were re-educated by the Director of Nursing (DON) on 9/17/12 on the policies and procedures related to proper reporting of allegations of abuse, neglect and misappropriation of property. All staff will be re-educated on the policies and procedures related to reporting	10/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 10/12/12

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.

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

PRINTED: 10/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		C 09/20/2012

NAME OF PROVIDER OR SUPPLIER: BOWLING GREEN NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 225	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, and review of the facility's policy/procedure, it was determined the facility failed to follow the "Abuse" policy/procedure for one resident (#1), in the selected sample of three residents, as evidenced by the failure to report an allegation of sexual abuse immediately to the State Agency. Findings include: A review of the facility's policy/procedure, "Abuse and Neglect Policy," undated, revealed "Any person who suspects that abuse, neglect, or misappropriation of property may have occurred, will immediately report the alleged violation to the facility Administration and any necessary advocacy agencies." A record review revealed the facility admitted Resident #1 on 06/10/03 with diagnoses to include Severe Dementia/Alzheimer's Type and Depressive Disorder. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/06/12, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated severe cognitive impairment.	F 225	allegations of abuse, neglect and misappropriation of property by the Administrator, DON and/or Education and Training Director by 10/26/12. 4. The Administrator will audit all resident concerns and any allegations weekly for twelve (12) weeks to ensure that all allegations of abuse or neglect have been reported appropriately. Ten (10) staff interviews will be completed weekly for four (4) weeks and five (5) staff interviews will be completed weekly for eight (8) weeks to ensure understanding of the policies and procedures related to abuse/neglect/misappropriation reporting and to ensure that all allegations of abuse, neglect or misappropriation have been reported appropriately. The audits will be reviewed by the Quality Assurance Committee monthly for three (3) months to ensure continued compliance. If at any time concerns are identified, they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the	

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

PRINTED: 10/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		C 09/20/2012

NAME OF PROVIDER OR SUPPLIER: BOWLING GREEN NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 225	Continued From page 2 A review of the facility's investigative report, dated 09/17/12, revealed an allegation of sexual assault was reported to the facility on 09/16/12. Upon questioning, Resident #1 stated, on the previous night, he/she was "raped" by a man while in his/her room. He/she was unable to give any further details regarding the alleged event. The physician and family were notified regarding the allegation. Further review of the facility's investigative report further revealed a physical examination was completed on Resident #1 by Registered Nurse (RN) #2. There was no evidence of bruising, redness or tearing in the genital area. The resident was then sent to the Emergency Room for an evaluation. An interview with Licensed Practical Nurse (LPN) #1, on 09/19/12 at 3:30 PM, revealed Resident #1 came to the nurse's station, on 09/16/12 at approximately 10:00 AM, and reported to her that someone came into his/her room the previous night and "raped" him/her. She reported the allegation to LPN #2 at approximately 10:15 AM. She further stated LPN #2 instructed her to notify the Director of Nursing (DON). LPN #1 stated she was busy and did not contact the DON at that time. She reported to the on-coming RN (#2) at approximately 1:45 PM, that Resident #1 alleged he/she was "raped" last night. LPN #1 stated RN #2 advised her to call the DON immediately; however, she stated she should have notified the DON when Resident #1 first reported the incident to her. An interview with LPN #2, on 09/19/12 at 3:55 PM, revealed LPN #1 told her that Resident #1 came to her on 09/16/12, and reported being	F 225	Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager and Medical Director at least quarterly. **THE SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION BY THE PROVIDER OF ANY FACT OR CONCLUSION SET FORTH IN THE STATEMENT OF DEFICIENCY. THIS PLAN OF CORRECTION IS BEING SUBMITTED BECAUSE IT IS REQUIRED BY LAW.**	

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

PRINTED: 10/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		C 09/20/2012

NAME OF PROVIDER OR SUPPLIER
BOWLING GREEN NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1561 NEWTON AVE.
BOWLING GREEN, KY 42104

(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 225	Continued From page 3 "raped" the previous night. She was unable to recall the exact time LPN #1 reported the alleged incident to her. She instructed LPN #1 to write a statement and fill out the behavior sheet. She stated, "I should have called the DON immediately." An interview with the DON, on 09/20/12 at 12:40 PM, revealed she received a call from LPN #1 on 09/16/12 at approximately 2:00 PM. LPN #1 informed her that Resident #1 reported that he/she was "raped" last night. She stated the nurse should have called her immediately, and not waited until the end of the shift. She further stated the nurses did not follow the facility's policy/procedure. An interview with the Administrator, on 09/20/12 at 1:20 PM, revealed the the nurses did not report the allegation of sexual abuse immediately. They reported the allegation to the DON on 09/16/12 at approximately 2:00 PM; however, the allegation should have been reported immediately.	F 225		