

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 04/11/2012
NAME OF PROVIDER OR SUPPLIER MAPLE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345	
(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 #18109) was conducted on 04/10/12 through 04/11/12 to determine compliance with Federal requirements. KY #18109 was substantiated with unrelated deficiencies cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to implement their policy and procedure which prohibits mistreatment and abuse of residents related to a physical altercation between two residents (#3 and #4), in the selected sample of four residents. On 03/29/12 at approximately 7:00 PM, Certified Nurse Aide (CNA) #5 and CNA #6 and the Resident Council President observed Resident #4 involved in a physical altercation with Resident #3, as the residents sat in their wheelchairs on the "B" hall. CNA #5 stated she immediately separated the two residents and reported the incident to the Unit Nurse, Registered Nurse (RN) #1. There was no evidence RN #1 initiated an investigation immediately to identify the root cause of the altercation or notified the Administrative Staff. Findings include:	F 226	F226 Development/Implement Policies for Abuse/Neglect It is the practice of Maple Manor to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Corrective action for residents found to have been affected by the deficient practice: Body audits of resident #3 and resident #4 were conducted by the Unit Manager and the Charge Nurse. Resident #3 was visited by the Social Service Director to assess for fears or concerns. Resident #3 was monitored daily per nursing x 72 hours for any adverse emotions from the incident. Social services visited resident #3 daily x 72 hours to allow time for the resident to express any concerns or fears. Resident #4 was placed on daily monitoring per nursing x 72 hours to observe for any mood or behavior concerns. Social Services visited resident # 4 daily x 72 hours to allow time to express any anger or mood concerns. Resident #4 was referred to the psychologist for follow up visits.	5/25/12

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

TITLE

(X6) DATE

Olivia Mey

Administrator

5/3/12

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 226	Continued From page 1 A review of the facility's policy and procedure "Abuse," dated 10/26/11, revealed all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property was to be reported immediately to the administrator of the facility and to other officials in accordance to the State law through established procedures (including to the State survey and certification agency). A record review revealed the facility admitted Resident #3 on 04/23/02 with diagnoses to include Cerebrovascular Accident, Convulsions NEC, Obstructive Hydrocephalus, Embolism without infarct, Depressive Disorder, Unspecified Hemiplegia and Generalized Anxiety. A review of the quarterly Minimum Data Set (MDS), dated 02/07/12, revealed the resident was cognitively impaired with a Brief Interview Mental Status (BIMS) score of "5." An attempt to interview the resident revealed he/she was not interviewable. A record review revealed the facility admitted Resident #4 on 04/20/11 with diagnoses to include Depressive Disorder, Anxiety, Hemiplegia right side, Hypothyroidism, Chronic Pain, Aphasia, History of Larynx Cancer and Tracheostomy. A review of the annual MDS, dated 02/14/12, revealed the resident's BIMS score was "15." An interview with Resident #4, during a tour of the facility on 04/10/12, revealed Resident #3 hit him/her, so he/she hit Resident #3 back. No further details were provided. An interview with CNA #5 on 04/10/12 at 2:50 PM, revealed, on 03/29/12 at approximately 7:00	F 226	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Identify other residents having the potential to be affected: Residents with BIMS score of 13-15 were interviewed by the administrative staff to identify if there were concerns of mistreatment or abuse with no concerns identified. The Administrator and Director of nursing will conduct observations for signs of abuse with a sample group of 10 non-interviewable residents. Measures put into place or systemic changes to ensure that the deficient practice will not recur. The licensed nurses were re-educated on Assessment and Root Cause Analysis by the Staff Development coordinator. Facility staff were re-educated on Abuse and Reporting Abuse (Policy 504-01) by the Staff Development Coordinator. The resident behavior books are to be reviewed weekly x 12 weeks by the Interdisciplinary Team to ensure that all behaviors have been appropriately assessed, reported, and followed up with any needed actions. The Director of Nursing, Unit Manager, and/or the Staff Development Coordinator will conduct audits with four staff members weekly x 12 weeks to identify and ensure that there are no unreported occurrences of mistreatment or abuse.		

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F 226	<p>Continued From page 2</p> <p>PM, she left the "C" wing and was walking toward the "B" wing. She stated she observed Resident #3 "bump" into Resident #4's wheelchair. She stated she did not observe Resident #3 hit Resident #4; however, she did observe Resident #4 hit Resident #3's arm. She revealed she immediately separated the two residents and reported the incident to the "B" wing Unit Nurse, and she also told the two CNAs working on the "B" wing to keep Resident #3 and Resident #4 separated.</p> <p>An interview with CNA #6, on 04/10/12 at 2:15 PM, revealed, on 03/29/12 at approximately 7:00 PM, she witnessed Resident #3 and Resident #4 trying to hit each other. She stated CNA #5 also witnessed the incident and reported to the unit nurse.</p> <p>An interview with RN #1, on 04/11/12 at 3:00 PM, revealed she was down the hall passing medication and taking care of other residents when CNA #5 informed her about an altercation between Resident #3 and Resident #4. She stated CNA #5 reported that she separated the two residents. RN #1 stated she spoke to the CNAs, who worked on "B" wing, but did not witness the incident. She revealed she did not ask CNA #5 who witnessed the incident. She stated she was not aware of any physical contact between the two residents. Additionally, she stated she was trained by the facility to investigate any resident to resident altercation and to report it immediately to the Administrator; however, she did not consider the incident a "big deal," but merely a "traffic jam," due to the fact that Resident #3 appeared upset that Resident #4 would not move his/her wheelchair.</p>	F 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Social Service Director or designee will conduct audits with four residents weekly x 12 weeks to identify and ensure that there are no unreported occurrences of mistreatment or abuse.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>Findings from the interviews will be reviewed in the monthly Performance Improvement meetings for three months and then as needed afterward to validate compliance is being met with assessment, reporting, and investigating per Kindred Policy and Procedure, Kentucky State Regulations, and Federal Regulations.</p>		

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F 226	<p>Continued From page 3</p> <p>An interview with the Resident Council President, on 04/10/12 at 1:20 PM, revealed he/she observed Resident #3 and Resident #4 involved in an altercation about a week ago. He/she stated Resident #4 hit Resident #3, then both residents started "swinging" at each other. The Resident Council President stated that he/she reported the incident to the Social Services Director.</p> <p>An interview with the Social Services Director, on 04/10/12 at 3:00 PM, revealed the Resident Council President notified her about the altercation between Resident #3 and Resident #4 that morning, on 04/10/12, and an investigation was initiated. She revealed she had no prior knowledge of the incident.</p> <p>A review of the facility's investigation summary, dated 04/10/12, revealed Resident #3 was found to have memory and cognitive impairments, but was able to carry out conversations with others. Resident #3 recalled having an argument with Resident #4, but did not recall the date; however, he/she stated Resident #4 was not physically aggressive toward him/her. Further review of the investigation summary revealed an interview was conducted with Resident #4, who stated he/she was in the hallway in his/her wheelchair attempting to get by Resident #3, who was also in a wheelchair. Resident #4 revealed he/she "bumped" into Resident #3's wheelchair and Resident #3 became angry and hit Resident #4, who then struck back at Resident #3. No injuries were noted.</p> <p>An interview with the Administrator and the Director of Nursing (DON), on 04/11/12 at 4:55</p>	F 226			

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F 226	Continued From page 4 PM, revealed licensed staff were trained about conducting investigations by the Staff Development Coordinator. They would have expected RN #1 to initiate an investigation, on 03/29/12, to determine the root cause of the altercation between Resident #3 and Resident #4 by way of the Event Report, and that the incident should have been reported immediately.	F 226		
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