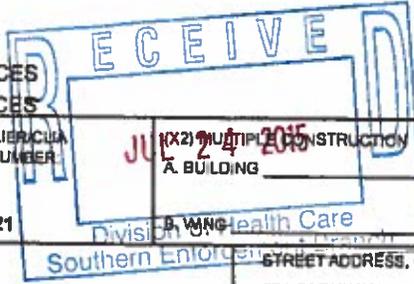


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE INSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2015
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of the 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 the provisions of federal and state laws require it. The provider maintains that the alleged deficiencies do no jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Condition of Participation	
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	F 225 483.13(c)(ii)-(iii), (c)-(4) INVESTIGATE/REPORT ALEGATIONS/INDIVIDUALS 1. SRNA #7 received a coaching and counseling on 7/10/2015 for not immediately reporting to administrative staff an allegation of abuse for Resident #2, however resident #2 immediately reported the allegation of abuse to the Director of Nursing. An immediate investigation was started on the date of occurrence by the Director of Nursing. SRNA #7 was interviewed by the Director of Nursing after resident #2 made the report to the Director of Nursing. SRNA #7 was re-educated on 7/10/15 by the Staff Development Nurse on abuse and neglect including when to report abuse and neglect. The facility provided immediate safety for resident #2 removing SRNA #6 from facility. SRNA #6 is no longer employed by facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doree Jones TITLE: Administrative (X6) DATE: 7/24/15

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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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41466		
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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 interview, record review, review of the facility's investigation, and facility policy and procedures review, it was determined the facility failed to ensure an allegation of abuse was reported immediately to administrative staff for one (1) of four (4) sampled residents (Resident #2). On 06/30/15, Resident #2 reported to the Director of Nursing (DON) that State Registered Nurse Aide (SRNA) #8 had been "hateful" and "mean" to the resident. Resident #2 revealed SRNA #7 witnessed the incident; however, SRNA #7 did not report the incident to the DON until she was questioned about the incident.</p> <p>The findings include:</p> <p>A review of the facility procedure titled "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property," revealed all staff was required to report alleged violations to the Administrator and DON immediately.</p> <p>A review of the medical record for Resident #2 revealed the facility readmitted the resident on 05/19/14 with diagnoses including Bipolar Disorder, Hypertension, and Anxiety. A review of the quarterly Minimum Data Set (MDS)</p>	F 225	<p>2. Social Services interviewed residents with a BIMS score of 8 and above on 7/16/2015 to see if they were treated with dignity and respect or felt they had been abused in any way, no issues were identified. Administrative nursing staff completed an observation of residents with a BIMS score below 8 on 7/17/2015 to observe for non-verbal symptoms of abuse or neglect, no issues were identified.</p> <p>3. Re-education was completed including a quiz by the Staff Development nurse for staff on abuse and neglect including when to report abuse and neglect on 7/17/2015. New hires will continue to be educated during general orientation by the Staff Development Nurse on abuse and neglect including when to report abuse and neglect. The Staff Development nurse or Nursing Administration will re-educate staff as needed for continued compliance.</p> <p>Social Services attended the resident council meeting on 7/6/2015 to review resident rights and abuse with the residents.</p> <p>Social Services will randomly interview 10 residents each week with a BIMS score of 8 and above to see if the residents are being treated with dignity and respect or feel they had been abused in any way beginning the week of 7/23/2015 times 8 week. Administrative nursing staff will observe 10 residents with a BIMS score below 8 beginning the week of 7/23/2015 to observe for non-verbal symptoms of abuse or neglect times 8 weeks.</p>		

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F 225	<p>Continued From page 2</p> <p>assessment, dated 06/24/15, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p> <p>A review of the facility's investigation, dated 06/30/15, revealed Resident #2 reported to the DON that SRNA #6 had been "hateful" and "mean" when the resident had an incontinence episode and requested to be cleaned up by SRNA #6. The investigation further stated the resident reported that SRNA #7 witnessed the incident. The investigation further revealed Resident #2 reported SRNA #6 "went off on the resident" and SRNA #6 "acted like she was mad" because she had to clean up Resident #2. The investigation revealed SRNA #7 was interviewed and reported she felt SRNA #6 was "a little hateful" to Resident #2 and it "hurt" SRNA #7 to see someone talk to a resident that way. Further review of the investigation revealed SRNA #6 was immediately suspended and removed from resident care. The allegation was unsubstantiated by the facility; however, SRNA #6 was terminated as a result of the investigation because the facility determined that the actions by SRNA #6 were inappropriate and the facility would not support the behavior.</p> <p>Interview on 07/07/15 at 5:15 PM with Resident #2 revealed the resident informed SRNA #6 the resident needed to use the restroom and was informed by SRNA #6 she would have to get the lift and someone to help with the transfer. The interview further revealed SRNA #6 and SRNA #7 returned with the lift and Resident #2 informed the staff he/she already "went" on his/her self. Resident #2 stated SRNA #6 "grabbed" the wheelchair, turned the resident around, and took</p>	F 225	<p>4. Results will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation.</p>	7/24/2015

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F 225	<p>Continued From page 3</p> <p>the resident to his/her room. The interview revealed SRNA #6 was very "hateful" and "mean" and appeared to be angry while she was cleaning the resident. The interview further revealed after the incident Resident #2 asked SRNA #7 if she was going to tell the DON how SRNA #6 had treated the resident. Resident #2 stated that SRNA #7 informed the resident that the resident would have to report the incident. Resident #2 stated he/she reported the incident to the DON right away.</p> <p>Interview on 07/08/15 at 11:15 AM with SRNA #6 revealed on 06/30/15 Resident #2 informed the SRNA the resident needed to use the restroom. SRNA #6 stated she went to get the lift and SRNA #7 to assist with the transfer. The interview further revealed when SRNA #6 returned to Resident #2 the resident informed her that he/she "went" on his/her self. The interview further revealed Resident #2 kept saying he/she was sorry and SRNA #8 stated she reassured the resident that accidents happen. SRNA #6 revealed she and Resident #2 "joked" and "fussed" with each other all the time and the SRNA did not feel like she had been mean to the resident in any way.</p> <p>Interview on 07/08/15 at 11:30 AM with SRNA #7 revealed on 06/30/15 SRNA #6 asked her to assist her with toileting Resident #2 and when the SRNAs returned to Resident #2 the resident reported to the staff that he/she had an accident. The interview further revealed SRNA #6 rolled her eyes at Resident #2, grabbed the wheelchair roughly, and pushed the resident to his/her room. The Interview revealed SRNA #6 had a "hateful" tone of voice and made comments to Resident #2 that the resident was not the only resident that</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>needed help in the facility. SRNA #7 revealed Resident #2 informed SRNA #6 that she did not have to be so hateful and kept apologizing for having the accident and SRNA #7 kept reassuring the resident that accidents happen and it was no problem to clean the resident. SRNA #7 revealed she assisted SRNA #6 to clean the resident and transfer the resident back to the resident's wheelchair. The interview revealed Resident #2 looked very sad after the incident and SRNA #7 was "hurt" and "cried on the inside" that SRNA #6 had talked to the resident in a hateful manner. SRNA #7 stated that the DON questioned her later in the shift about the incident and informed SRNA #7 she would have to write a statement about the incident. SRNA #7 stated that the incident should have been reported to the DON as soon as it happened, but she was responsible to open the smoke room immediately after the incident occurred and felt that it was more important than reporting the incident to the DON. SRNA #7 further revealed Resident #2 had previously made comments such as "oh no, not her again" when the resident was informed SRNA #6 would be providing care for the resident. SRNA #7 stated she reported the resident's comments to the Unit Manager in the past, but did not know when.</p> <p>Interviews on 07/07/15 with Licensed Practical Nurse (LPN) #1 at 4:43 PM and Registered Nurse (RN) #1 at 4:25 PM revealed Resident #2 would often ask which staff would be providing care for the resident and when informed SRNA #6 would be providing care to the resident the resident would make comments such as "not her again." The interviews further revealed Resident #2 never reported that SRNA #6 was mean to him/her, never requested to not have SRNA #6</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>provide care to the resident, and never reported a specific incident about SRNA #6. The nursing staff revealed the Unit Manager (RN #2) had been made aware of the comments Resident #2 made about SRNA #6. The interviews revealed the nursing staff had never witnessed SRNA #6 be mean or rude to a resident.</p> <p>Interview on 07/07/15 at 5:06 PM with RN #2 (Unit Manager) revealed she had never been made aware Resident #2 had made comments about SRNA #6 and if she had been made aware, she would have looked into the situation. RN #2 denied witnessing SRNA #6 being mean or hateful to any residents.</p> <p>Interview on 07/08/15 at 4:28 PM with the DON and the Administrator revealed the allegation was investigated and the facility did not substantiate abuse; however, they felt SRNA #6's actions were not appropriate. The interview further revealed SRNA #7 should have immediately reported the incident to the DON or the Administrator. The administrative staff denied being made aware Resident #2 had made previous comments about SRNA #6 or of any concerns regarding SRNA #6.</p>	F 225			