

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

PRINTED: 03/03/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/20/2015
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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320
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(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
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating Complaint #KY22785 was conducted on 02/13/15 through 02/20/15. KY#22785 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".	F 000	F 226 Abuse The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	
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 facility policy review it was determined the facility failed to implement the facility's "Personal Care Alleged Abuse/Potential Neglect/Exploitation Reporting/ Investigation policy and procedure for one (1) of three (3) sampled residents (Resident #1). The facility failed to follow there policy and procedure related to conducting an investigation prior to unsubstantiating the allegation and allowing the alleged perpetrator to return to work. Skin assessments on eighteen (18) non-interviewable residents on the wing the alleged incident of abuse occurred on were not completed until after the alleged perpetrator had returned to work. The findings include: Review of the facility's policy titled, "Personal Care Alleged Abuse/Potential Neglect/Exploitation Reporting/ Investigation", not dated revealed it	F 226	Criteria 1: Resident #1 is unable to answer interview questions, so a head-to-toe skin assessment was performed on 1/26/15 by ADONs. No signs/symptoms of physical/mental abuse were noted, as evidence by: no suspicious bruising, no changes in mood/behavior, Criteria 2: Residents on the same wing as this resident with BIMS score of 8 or above were interviewed on 1/26/15 by SSD and Administrator with questions about staff treatment. Those residents with BIMS below 8 had head-to-toe skin assessments completed 1/29/15 by North Station RN. No allegations of abuse were made by residents and no suspicious bruises/marks were found during skin assessments. Criteria 3: All facility staff received in-service education on the facility's policy/procedure on resident abuse on 1/26/15 as provided by MDS Coordinator and DON. A post-test was given with 100% pass score required. No staff member will be allowed to return to work until they have received the in-service education and successfully passes the post test. The DON received in-service education the on abuse investigation process (including, but not limited to: identifying other residents having the potential to be affected by the allegation and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 3-16-15
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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>was the policy of the facility to provide an environment that promotes dignity and respect for residents and one that prohibits abuse and/or neglect against a child or elderly person. Any person who know or has reasonable cause to suspect that a resident has been or is being abused, neglected or exploited shall immediately report such knowledge or suspicion to their supervisor, charge nurse, designee, or Administrator. Allegations of abuse and potential neglect/exploitation should be thoroughly investigated. The investigation will be initiated as soon as alleged abuse, potential neglect/exploitation has been identified. The Administrator, or designee, will complete the investigation process.</p> <p>Record review revealed the facility admitted Resident #1 on 09/06/13 with diagnoses which included Dementia with Behaviors, and Bipolar Disorder.</p> <p>Review of facility initial investigation, dated 01/28/15, revealed there was an alleged altercation between Resident #1 and Licensed Practical Nurse (LPN) #1 reported by State Registered Nursing Assistant (SRNA) #1. LPN#1 was immediately suspended and the resident was assessed for injury with no injury noted. Review of the facility's final investigation, dated 01/29/15, revealed LPN #1 was reinstated to job duties on 01/28/15 following a thorough investigation by the facility and the allegation was unsubstantiated.</p> <p>Further review of the facility's investigation to include skin assessments, revealed skin assessments were conducted on eighteen (18) non-interviewable residents on 01/29/15 (three days after the alleged incident and one day after</p>	F 226	<p>assessing them in a timely manner) as provided by the nurse consultant on 2/20/15.</p> <p>The DON provided in-service education to the administrative nursing staff and facility administrator on abuse investigation process (including, but not limited to: identifying other residents having the potential to be affected by the allegation and assessing them in a timely manner) on 2/20/15.</p> <p>Criteria 4: The QA monitoring tool for monitoring of Abuse Policy and Investigation process will be used with each allegation made for 2 months, and then the tool (which allows for up to 5 reviews) shall be completed quarterly under the supervision of the Administrator. Results of the audits will be reported to the QA Committee by the Administrator or DON each month it is completed. If an accepted threshold of compliance is not achieved, the Administrator or DON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Members of the QA Committee include: Administrator, Director of Nursing, Medical Director, ADON, Social Services/Admission Director, Activities Director, Maintenance Director, Dietary Manager, and Business Office Manager.</p> <p>Criteria 5: Target Date</p>	3/18/15	

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F 226	Continued From page 2 the alleged perpetrator returned to work) to identify if there were any signs and symptoms of abuse. Interview with the Director of Nursing (DON), on 02/19/15 at 1:47 PM, revealed the skin assessments on non-interviewable residents were not completed until 01/29/15, three days after the allegation was made and one day after LPN #1 had returned to work.	F 226			