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

PRINTED: 05/25/2012
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
	185279		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLS HEALTH & REHAB CENTER, INC	500 BECK LANE MAYFIELD, KY 42066

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F 000	INITIAL COMMENTS An abbreviated survey (KY #18215) was conducted on 05/04/12 through 05/11/12 to determine the facility's compliance with Federal requirements. KY #18215 was unsubstantiated with deficiencies cited.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
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 and procedure, it was determined the facility failed to ensure the policy and procedures were implemented that prohibited the mistreatment, neglect, and abuse of residents for one resident (#1), in the selected sample of three residents. On 04/09/12, Certified Nurse Aide (CNA) #1 and CNA #2 transferred Resident #1 from his/her wheelchair to the shower chair in the shower room. It was alleged the resident called CNA #2 a "black bitch" during the transfer. CNA #2 allegedly pulled the resident's hair on two different occasions during the transfer, and then exited the shower room. She waited in the hall to see if CNA #1 needed further assistance, and approximately ten minutes later, CNA #2 re-entered the shower room. She was informed by CNA #3, that the situation was under control and her assistance was not needed. CNA #2 went on her lunch break and CNA #1 reported to Licensed Practical Nurse (LPN) #1 that she	F 226	**F 226 483.13(c)DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES** It is the normal practice of Mills Health and Rehab Center to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **Corrective Measures for Resident Identified in the deficiency:** Resident # 1 was assessed on 4/9/12 by the licensed nurse for possible physical trauma related to the allegation of abuse. No pink areas were noted to the scalp and no missing hair in the identified area. On 4/11/12 Social Service Director visited with resident # 1 to identify any possible adverse affects from the incident and determine if there was a need for additional psychosocial support and no issues were identified.	5/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/31/12

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 observed CNA #2 pull Resident #1's hair twice during the transfer and repositioning of the resident on the shower chair. LPN #1 reported the allegation to the Director of Nursing (DON). CNA #2 was paged over the intercom system to report to the DON's office and CNA #2 walked alone through the resident dining room and up the center hall of the East wing to the DON's office. There were 18 residents residing in this area. The facility failed to protect the other residents in the facility by not escorting CNA #2 to the DON's office and ensuring further potential harm to other residents within the facility after an allegation of abuse was made. Findings include: A review of the facility's policy/procedure, "Alleged Abuse/Potential Neglect/Exploitation Reporting Investigations," dated 01/01/07 and revised 03/21/12, revealed it is the policy of this facility to provide an environment that promotes dignity and respect for residents and one that prohibits abuse and/or neglect. Allegations are to be reported to the supervisor and the resident's charge nurse. Person receiving the report are to immediately inform the Administrator. Interventions to protect the resident(s) should be taken to avoid potential for harm during the investigative process. In order to prevent potential harm while the investigation is in progress, any employee accused will be relieved from duty until the timely investigation is complete. The name of the person reporting the allegation will remain confidential, only being disclosed to the agencies involved. The investigation will be conducted in a manner that attempts to protect the privacy and confidentiality of the victim, the person reporting	F 226	F 226(cont) On 5/22/12 in conjunction with resident # 1's physician, the facility obtained an order for a referral to a Behavioral Health Center. Resident # 1 was transferred on 5/22/12 to a Behavioral Health Center for evaluation and treatment. **How other residents who may have been affected by this practice were identified:** All inter-viewable residents in the facility were interviewed by the Social Service Director on 4/9/12 to verify that residents voiced no complaints of abuse, neglect or mistreatment. Interviewed residents voiced no issues. All non-interviewable residents were assessed on 4/9/12 by the licensed nurse to identify any signs of trauma that could relate to an act of abuse and no issues were identified. **Measures Implemented or Systems altered to Prevent Re-Occurrence:** CNA # 1 was re-educated on 4/9/12 on the abuse policy and procedure with emphasis placed on providing safety for the resident. This was conducted by the Director of Nursing. CNA # 2 is no longer an employee at the facility. Re-education on the abuse policy and procedure was initiated on 4/10/12 which included a post test for staff, and will continue until all staff are re-educated. This was conducted by Director of	

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F 226	Continued From page 2 and the alleged perpetrator. A record review revealed the facility admitted Resident #1 on 11/22/02, and re-admitted on 12/07/10, with diagnoses to include Altered Mental Status, Cerebrovascular Disease, Mixed Hearing Loss, Avulsion of Right Eye and Acute Ischemic Heart Disease. A review of the quarterly Minimum Data Set (MDS), dated 02/29/12, revealed Resident #1 was assessed as severely cognitively impaired and did not make any decisions. A review of the facility's investigation, dated 04/09/12 around 10:45 AM, revealed CNA #1 reported to LPN #1 she observed CNA #2 pull Resident #1's hair two times in the shower room. The resident confirmed his/her hair was pulled two times but he/she could not identify the staff member who did it. Upon the completion of the investigation, it was determined that abuse occurred through the eyewitness account and the resident's account. The resident's cognitive ability was diminished; however, the resident's account of the event was consistent with the observation, and the report from the CNA eyewitness. An interview with Resident #1, on 05/11/12 at 2:30 PM, revealed he/she was lying in the bed on his/her left side and was tearful. The resident stated he/she "could not find the little girls" and did not know where they were. Resident #1 was unable to state who the "little girls" were, but stated the "girls" working there were nice to him/her. The resident stated his/her hair was pulled all the time, but he/she could not state when it happened or who did it.	F 226	F 226(cont) Nursing, Staff Development Nurse and/or Administrator. The Director of Nursing and/or Staff Development Nurse will be responsible to provide or arrange education for those staff who are inactive. Re-education of all facility staff in regards to the abuse policy and procedure with emphasis on resident protection, which specifically included that once the allegation is made, provide safety to the resident, the accused perpetrator must not be left unattended at any time, and the alleged perpetrator is to be immediately escorted from resident area. The nursing supervisor and/or charge nurse will be notified. Person receiving the report will immediately notify the administrator. The alleged perpetrator is to be escorted to the Administrator or Director of Nursing office. If the alleged perpetrator is an employee, they will be immediately relieved from duty until the investigation has been completed. This re-education was initiated on 5/11/12 by the Quality Management Nurse. Education will continue until all staff are re-educated on the abuse policy and procedure. This will be conducted by the Director of Nursing, Staff Development Nurse and/or Administrator. A follow up post test on abuse policy and procedure will be utilized to validate on-going understanding of training received.	

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F 226	Continued From page 3 An interview with CNA #1, on 05/06/12 at 4:51 PM, on 05/09/12 at 12:01 PM, and on 05/11/12 at 12:23 PM, revealed she was the shower aide in the shower room with Resident #1, on 04/09/12 around 10:45 AM. She stated she called CNA #2 into the shower room to assist with transferring Resident #1 from the wheelchair to the shower chair. She revealed the resident was "cursing staff and fighting" when assisted to the shower room. CNA #1 and CNA #2 moved the resident to the shower chair and CNA #2 "got mad, then jerked the [resident's] head back." Resident #1 cried and yelled "that black bitch pulled my hair" and repeated it 4 or 5 times. CNA #1 told the staff to stop and as CNA #2 was leaving the shower room, she called CNA #2 back to assist with repositioning the resident on the shower chair. The CNAs repositioned him/her and Resident #1 called CNA #2 a "black bitch," and again CNA #2 pulled the resident's hair. CNA #1 told CNA #2 to leave the shower room, then she moved the resident to the area where she conducted the showers and pulled the emergency light. LPN #1 responded to the light and CNA #1 informed her of what happened. LPN #1 reported the incident to the Director of Nursing (DON) and later CNA #2 was over heard being paged to the DON's office. CNA #1 revealed the incident with CNA #2 only lasted two to three minutes and she did not see CNA #2 after she had left the shower room. An interview with CNA #3, on 05/10/12 at 5:21 PM, revealed she did not recall assisting with Resident #1 or recall CNA #2 coming into the shower room and asking if the staff needed help with Resident #1.	F 226	F 226(cont) **Monitoring Measures implemented to maintain ongoing compliance:** The Director of Nursing, Staff Development Nurse and/or Charge Nurse will conduct interviews with 30 staff members (approx. 30% of facility employees) to verify on-going compliance with the abuse policy and procedure with emphasis being placed on the protection aspect. The interviews will be conducted on various shifts and departments. The sampled employees interviewed will be rotated so repeat interviews are avoided, until all employees in their given department, shift or unit have been completed. This will be done monthly X 2 months, then quarterly X 6 months. Results of the interviews will be reported to the administrator and also to the Quality Assessment and Assurance Committee for review. If any areas of concerns are identified the frequency and duration of interviews will be increased. Re-education will be provided on a individual basis if indicated. Audits will be conducted on all investigations by the Administrator and Director of Nursing to validate that protection was provided to all residents, the alleged perpetrator was never left unattended at any time, and was immediately escorted to the Administrator or Director of Nursing office.	

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F 226	Continued From page 4 An interview with LPN #1, on 05/04/12 at 4:06 PM, and on 05/11/12 at 3:06 PM, revealed she was the nurse on duty on 04/09/12 when CNA #1 motioned for her to come into the shower room. CNA #1 reported to her that she saw CNA #2 pull the resident's hair two times while assisting with the resident's transfer. When CNA #1 reported to the LPN, CNA #2 had already left the shower room. CNA #1 reported Resident #1 had called CNA #2 a "black bitch," then she showed me how CNA #2 had pulled his/her hair. The CNA stated it happened two times and she reported the incident to the DON immediately. A head to toe assessment was completed on the resident in the shower and Resident #1's hair was wet with no pinkness noted to the scalp and there was no missing hair in the area. She revealed she was trained on abuse/neglect but could not recall how often. She was trained to keep the residents safe after an allegation of abuse, and that meant getting the person out immediately who harmed the resident, even if she had to go and find them in the facility. After reporting to the DON, she heard CNA #2 being paged on the intercom. An interview with CNA #2, on 05/10/12 at 8:20 AM, revealed, on 04/09/12 at 10:10 AM, she was called into the shower room to assist CNA #1 with transferring Resident #1 from the wheelchair to the shower chair. CNA #1 positioned herself in front of the resident and explained she was going to give the resident a shower. Resident #1 was hard of hearing. The resident "screamed and hollered" that he/she did not want a shower and the CNAs assisted the resident to stand up, pulled his/her pants and incontinent brief down, and then pulled the shower chair beneath the	F 226	F 226(cont) The audit will be conducted on all investigations of alleged abuse X 12 months. Results of the audit findings will be reported to the Monthly Quality Assessment & Assurance Committee for review. If any areas of concern are identified re-education will be provided on a individual basis as indicated.	

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F 226	Continued From page 5 resident. Resident #1 looked at CNA #2 and stated "you're black and you pulled my hair." CNA #2 stated she exited the shower room. CNA #2 denied pulling the resident's hair. CNA #2 re-entered the shower room about 10 minutes later and observed two other CNAs assisting CNA #1 with Resident #1. She informed those CNAs that she was going on lunch break. She clocked out at 10:20 AM and went to lunch in the facility's break room. She ambulated down the center hall of East wing, and around 11:00 AM she heard them page her overhead to come to the DON's office. She walked up the center hall of the East wing to the DON's office, and when she arrived, the DON and the Administrator were there. She was questioned about what had happened in the shower room with Resident #1. She explained Resident #1 stated she was "black and that she pulled [his/her] hair." She reported the resident had these behaviors often and the CNAs had not reported it because they dealt with it on a daily basis. The resident wore a sweatshirt during the night related to complaints of being cold and every morning when the CNAs changed his/her clothes, he/she would "fuss and curse," then stated the staff had pulled his/her hair. A review of CNA #2's time sheet, dated 04/09/12, revealed she clocked out for lunch at 10:21 AM and clocked back in at 10:51 AM. An interview with the Administrator, on 05/10/12 at 4:45 PM, revealed CNA #2's badge did not work when she clocked out for lunch and the time had to be added. Additionally, he stated the Human Resources Director had to add the time when the CNA left the facility grounds at 12:30 PM.	F 226		

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F 226	Continued From page 6 An interview with the DON, on 05/07/12 at 3:20 PM, on 05/10/11 at 4:35 PM, and on 05/11/12 at 4:35 PM, revealed she was informed about the incident shortly after it happened on 04/09/12. CNA #2 was pulled from the floor and into her office after the allegation was received. She could not say how CNA #2 was sought after, but she was sent home after being interviewed. She revealed she expected the staff to protect the resident when CNA #1 observed CNA #2 pull the resident's hair. CNA #1 could have asked CNA #2 to leave the room and have her send another staff member in there, or she could have put on the light. The incident was replayed and the resident was on the edge of the chair. CNA #1 was concerned the resident would fall and that was the safety aspect. CNA #1 called CNA #2 back to assist with repositioning the resident so he/she would not fall. During the investigation, Resident #2 was checked over and there was no redness or loose hair. Other non-interviewable residents were checked, and interviewable residents were interviewed with no issues identified. Resident #2 was able to state his/her was pulled twice but unable to state who pulled his/her hair. The resident stated there was a "blonde lady" and a "black lady" in there. During the interview with CNA #2, she denied the allegation, and prior to the shower, the resident commented on his/her hair being pulled and using foul language. During an abuse allegation, our priority was to protect the resident and the staff responded appropriately in the incident. Further interview with the Administrator, on 05/11/12 at 4:35 PM, revealed when we were made aware of the incident, CNA #2 was paged	F 226		

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F 226	Continued From page 7 over the intercom to come to the DON's office. When we found out about the incident, somebody went to get the CNA. CNA #2 went straight to the DON's office, then out of the building. She was driven to her car, we watched her get in it, and then she drove off the property.	F 226		