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

PRINTED: 09/30/2011
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
	185332		C 09/16/2011

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO#KY00017010 and ARO#KY00017097 was initiated on 09/14/11 and concluded on 09/16/11. ARO#KY00017010 was unsubstantiated with no deficiencies and ARO#KY00017097 was substantiated with a deficiency cited.	F 000	I. Rsd #4 has expressed no fears or any further problems related to the actions of SRNA #1 who was terminated. II. The Social Service Director conducted interviews with residents to determine if other instances of abuse had occurred. No residents interviewed reported any allegations. The interviews were completed on 9/11/11 and 9/12/11. III. The Social Service Director conducted an in-service on 10/5/11 with all staff regarding the abuse policy and all staff have completed a test to validate that the information was understood. The abuse policy has been amended to include immediate suspension of any employee that has an allegation of abuse against them during the investigational process and all employees have been in-serviced on the policy revision on 10/5/11. The Social Service Director will be responsible for providing this in-service to all staff each quarter for the next year. IV. A quality assurance tool has been developed that will be completed by the social services director or her designee and used to audit 100% of allegations of abuse/neglect to ensure compliance with the abuse prevention policy. The results of this audit will be reported to the Quality Assurance Committee each month by the Administrator.	Completion 10/7/11
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	F 225		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thom E. Nan | TITLE: LNHA | (X6) DATE: 10-19-11

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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Acceptable

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

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F 225	Continued From page 1 to the administrator or his designated 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 policy, and review of the facility time cards it was determined the facility failed to report to the Administrator and ensure residents were protected from abuse by failing to follow their "Abuse Policy", with the review date of 03/16/11, for one (1) of four (4) sampled residents, Resident #4. Resident #4 was observed to have been "flipped" across the knees with a wet shirt by State Registered Nursing Assistant (SRNA #1) and SRNA #2 was the person who witnessed this incident on 09/11/11. SRNA #2 stated she reported the incident to the Nurse and then she and SRNA #1 finished their rounds. SRNA #2 indicated she was with SRNA #1 when she provided care to some of the residents and was not with her for some of the other residents after the incident was reported. The findings include: Review of the facility's policy titled "Abuse Policy", with a review date of 03/16/11, revealed the Administrator would be notified immediately of all incidents and employees would be suspended pending the investigation if the allegation is for abuse/neglect. It was noted the policy failed to	F 225		

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F 225	Continued From page 2 mention the immediacy with which the employee would be suspended or removed from providing care to other residents. Review of Resident #4's medical record revealed the facility admitted the resident on 04/15/11 with diagnoses which included late effect Cerebrovascular Disease, Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitis type two (2) and Chronic Renal Insufficiency stage three (3). Interview with SRNA #2, on 09/16/11 at 4:48 PM, revealed on 09/11/11 about 5:30 AM, she had witnessed SRNA #1 flick Resident #4 across the knees with his shirt. She further indicated from the way SRNA #1 was talking to the resident, she was sure the resident had wet the bed and the resident's shirt was wet because SRNA #1 said to the resident "if you would use your urinal you wouldn't be in this kind of mess", before she flicked him/her with the shirt. She further stated SRNA #1 had left the room while the resident was on the commode and she took over assisting him/her and after she finished providing care for Resident #4 she went and told the Registered Nurse (RN) who was on duty. Further interview revealed SRNA #1 finished doing rounds providing care to residents that morning after SRNA #2 had reported the incident. She further stated she was with SRNA #1 when she was providing care to some of the residents, however, stated she was not present with SRNA #1 for all the resident's she provided care to on the morning of 09/11/11 after the incident was reported. Review of facility's investigation documentation	F 225		

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F 225	Continued From page 3 revealed the incident occurred on 09/11/11 at 5:30 AM and the Administrator was notified on 09/11/11 at 2:00 PM. Review of the "Employee Time Card" for SRNA #1 revealed on 09/11/11 the SRNA worked from 10:32 PM until 6:48 AM, at least an hour and fifteen (15) minutes after the incident occurred. Interview with the Social Services Director, on 09/15/11 at 3:00 PM, who was responsible for completing the abuse investigation, revealed the incident occurred at approximately 5:30 AM on 09/11/11. She further indicated once SRNA #2 told SRNA #1 she would finish taking care of Resident #4 then SRNA #1 left the building because it was the end of her shift. Interview further revealed she was not aware SRNA #1 continued to provide care to residents following the alleged incident. Interview with SRNA #1, on 09/16/11 at 11:14 AM, revealed she had been assisting the resident to get up at approximately 5:30 AM on 09/11/11. She further stated the resident was sitting on the commode and she took a urinal to him/her and the resident stated "damn it, if I wanted to use it I would". She further indicated the shirt had an approximately two (2) inch by four (4) inch area of urine on it and she had the wet part of the shirt in her gloved hand. Further interview revealed she jokingly said "you don't have to be so hateful" and tapped him on the legs with the dry part of the shirt. SRNA #1 further stated she worked the rest of her shift and no one said anything about the resident's allegation or the resident being upset and she was not asked to leave work or escorted out of the facility.	F 225		

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F 225	Continued From page 4 Interview with the Housekeeper, on 09/16/11 at 12:30 PM, revealed she had just entered work on 09/11/11 around 6:00 AM and saw Resident #4 in the hallway outside of his/her room. She further indicated she asked Resident #4 how they were doing and the resident replied "not to good one of the girls hit me with a shirt". She further stated she asked if he/she could remember the aides name, however, the resident could not remember the aides name. Further interview revealed the Housekeeper reported the incident to the Charge Nurse. Interview with RN #1, on 09/16/11 at 2:48 PM, revealed she was told by SRNA #2 on 09/11/11 about SRNA #1 flicking Resident #4 across the knees with a shirt at some time between 5:30 AM and 6:00 AM. She further stated when SRNA #2 told her she thought SRNA #1 must have just been teasing with Resident #4. She further stated while she was giving report to the day shift nurse someone reported Resident #4 had stated an aide had hit him/her in the face and legs with a shirt. Further interview revealed if the resident had told her, SRNA #1 had hit him in the face, she would have walked her out of the facility right then. Interview with Resident #4, on 09/16/11 at 3:20 PM, revealed the he/she had asked for assistance with using the commode, however, before he/she was assisted to the commode SRNA #1 provided him/her with assistance with changing his/her clothes because he/she had urinated in the bed and the residents clothes were wet. The resident further stated the SRNA #1 pulled his/her shirt off and slapped him/her	F 225		

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F 225	Continued From page 5 across the face with the wet shirt and then across his/her knees when the resident was on the commode. Further interview revealed SRNA #1 stated if the resident would use his/her urinal this kind of thing would not happen and the resident stated he/she responded by saying if "I wanted to use the urinal then I would if I don't then I will not". Interview with the Director of Nursing (DON), on 09/16/11 at 5:40 PM, revealed SRNA #1's action was inappropriate. She further stated she was unaware SRNA #1 had worked with other residents after the incident was reported. She further indicated staff are not supposed to be providing care or be in contact with other residents after an allegation of abuse was made.	F 225		