

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

PRINTED: 12/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/09/2011
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NAME OF PROVIDER OR SUPPLIER HIGHLANDSPRING OF FT THOMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 980 HIGHLAND AVENUE FORT THOMAS, KY 41075
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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	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey Investigating ARO #KY00017476, #KY00017475, and #KY00017472 was initiated on 12/09/11 and concluded on 12/09/11. ARO#KY00017476 was unsubstantiated with no deficiencies cited. ARO #KY00017475 was unsubstantiated with unrelated deficiencies cited. ARO #KY00017472 was substantiated with deficiencies cited: The highest scope and severity was a "D".</p> <p>483.13(o) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to follow their Abuse Policy for one (1) of four (4) sampled residents, (Resident #2), when Certified Nursing Assistant (CNA) #7 failed to report an allegation of abuse for two (2) days after the allegation occurred.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled Abuse/Neglect/Misappropriation of Property, dated Revised 9/11, revealed staff are to report all alleged violations immediately to the administrator of the facility and to other officials in accordance with state law.</p>	F 000	<p>Without admitting or denying the validity or existence of the alleged deficiencies, Highlandspring Health Care and Rehab ("Highlandspring") provides the following plan of correction.</p> <p>However, the law requires us to prepare a plan of correction for the citation regardless of whether we agree with this plan of correction is not meant to establish any standard of care, contract obligation, or position and Highlandspring reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. 3 2012</p> <p>THIS PLAN OF CORRECTION SERVES AS HIGHLANDSPRING'S CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF JANUARY 3, 2012.</p> <p>F226</p> <p>Highlandspring has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and the misappropriation of their property.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Molly Bischoff *Administrator* 12-29-11

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 discloseable 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 discloseable 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.