

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

PRINTED: 05/02/2012
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2012
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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40381
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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)	(X6) COMPLETION DATE
F 000 F 224 SS=D	<p>INITIAL COMMENTS</p> <p>An Abbreviated Standard Survey investigating complaint KY#00018188 was conducted 04/18/12 through 04/19/12. The complaint was substantiated with related deficiencies cited. In addition, two unrelated deficiencies were cited. 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</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 observation, interview, clinical record review, review of the facility's abuse policy and the facility's corrective actions (related to reported abuse event), it was determined the facility failed to implement all of the facility's corrective actions to prevent further occurrences of resident mistreatment for one (1) of three (3) sampled residents (Resident #2). The facility reported to the Office of Inspector General Resident #1 pinched Resident #2 on 04/02/12. Review of the corrective actions included an intervention to keep Resident #1 and Resident #2 apart. Observations on 04/18/12 and 04/19/12 revealed the facility failed to ensure the residents were kept separate. In addition, Interview of facility staff revealed the facility failed to inform all staff of the intervention to keep the Resident #1 and Resident #2 separate.</p>	F 000 F 224	<p>Residents were separated immediately. Resident #1 was discharged to Ephraim McDowell Psych Hospital for admission on April 20, 2012. Resident #2 was moved to another room while Resident #1 was at the hospital. Their mealtime seating arrangement was changed, also. Care plan was updated by Social Services on 4-19-12 to reflect interventions. In-service of all unit staff was conducted on 4-20-12 by Unit Coordinator to educate them on updated changes of separation.</p> <p>Quality Assurance Team and Care Plan Team evaluated the residents to see who would be most appropriate roommate for Resident #1. The new roommate was moved in Resident #1 room while she was in the hospital.</p> <p>No other residents were identified to be affected.</p> <p>An in-service addressing Care Plan updates and care of resident #1 was conducted on April 27, 2012 by Director of Nursing. All reports called into OIG will be handed out Quality Assurance team, which includes the care plan coordinator, to be discussed ensuring that all disciplines are aware of interventions. Those disciplines will forward information to unit staff via in-service forms. Social Services will document whom she educated with each incident.</p> <p>A staff member has been assigned one on one with Resident #1, while she is up in wheelchair, since her return from Psych Hospital. She is immobile with a two-person transfer while in bed. She also does not propel self in wheelchair while in it without assistance.</p> <p>One on one monitoring while resident #1 is up in wheelchair will be done until her transfer to another facility.</p> <p>5-1-12</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela D. Smith</i>	TITLE Administrator	(X8) DATE 5-17-12
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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 224	<p>Continued From page 1 The findings include:</p> <p>Review of the facility's policy: "Abuse, Neglect, and Exploitation", undated, revealed substantiated incidents will have corrective actions taken depending on the results of the investigation.</p> <p>Review of the medical record for Resident #1 revealed the resident was admitted by the facility, on 10/02/08, with diagnoses which included Anxiety, Depression, and Panic Attacks. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 02/08/12, revealed the assessed the resident as being severely cognitively impaired. Further MDS review revealed the resident was assessed as having physical behavioral symptoms directed toward others (e.g., hitting, kicking, scratching, grabbing) and verbal behaviors towards others (e.g., threatening others, screaming at others, cursing at others).</p> <p>Record review revealed a Behavior/Intervention Monthly Flow Record, for Resident #1, which monitored daily for the following behaviors: Anxiety and Hitting or Striking Out. Further review revealed documentation the resident was being monitored every fifteen minutes daily ("Fifteen Minute Monitoring Form") by aides for safety.</p> <p>Record review of nurse's notes revealed periodic episodes of physically abusive behaviors as evidenced by the following nurse's note documentation: date 03/29/12 at 8:31 PM revealed resident was yelling, scratching, slapping, and kicking at staff; date 03/30/12 at</p>	F 224		

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F 224	<p>Continued From page 2</p> <p>6:00 PM revealed the resident kicked nurse in leg, told the nurse she was going to punch her in face with her fist, and the resident was observed in hallway backing (wheelchair) into other residents and trying to roll over feet of other resident; date 03/31/12 at 3:55 PM resident was combative, hitting, scratching, kicking and kicked a female State Registered Nursing Assistant (SRNA) in the breast.</p> <p>Review of the medical record for Resident #2 revealed the resident was admitted by the facility on 12/27/96 with diagnoses which included Schizoid type personality, Anxiety State, and Alzheimer's Disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/25/12, revealed the facility assessed the resident as being moderately cognitively impaired.</p> <p>Record review of the nurse's notes for Resident #2 revealed, on 04/02/12 at 8:30 AM, the resident stated to the nurse and Director of Nursing (DON), that his/her roommate (Resident #1) pinched him/her over the weekend and tried to hit him/her. The resident further reported that there was no reason, just that Resident #1 was mad. The note indicated staff checked the resident's upper left arm and an eraser size petechia area was observed and Social Services was notified.</p> <p>Review of the facility's report of a resident to resident abuse incident submitted to the Office of Inspector General, dated 04/04/12, revealed on 04/02/12 that Resident #1 had pinched Resident #2 on the left arm on 04/01/12. The facility had performed a skin assessment on Resident #2 and the resident did have a bruise to her left arm.</p>	F 224			

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F 224	<p>Continued From page 3</p> <p>The corrective actions implemented by the facility included an intervention of staff keeping Resident #1 and Resident #2 apart.</p> <p>Observation during the initial tour of the facility, on 04/18/12 at 8:45 AM, revealed Resident #1 and Resident #2 were roommates at the facility. Observation, on 04/18/12 at 11:35 PM, revealed Resident #1 and Resident #2 were next to each other at same table in dining room. Observation on, 04/18/12 at 2:35 PM, revealed the residents were near each other at nurse's station on Unit One. Observation, on 04/19/12 between 8:45 AM and 8:50 AM revealed Resident #1 and Resident #2 were side by side in their wheelchairs in front of the Unit One nurses station. Staff were observed passing by the residents during this time.</p> <p>Interview with SRNA #7, on 04/19/12 at 8:52 AM, revealed she had moved Resident #1 to another area near the nurse's station on Unit One (1) away from Resident #2, because the nurse told her to. She further stated she did not know Resident #1 and Resident #2 were supposed to be separated.</p> <p>Interview with Resident #3, on 04/18/12 at 10:05 AM, revealed Resident #1 and Resident #2 had a history of verbally yelling at each other. The residents argued with each other about clothes items.</p> <p>Interviews with SRNA #1, on 04/18/12 at 10:50 AM and SRNA #3, on 04/18/12 at 1:30 PM, revealed each had cared for both residents. Resident #1 had a history of being verbally and physically abusive toward staff, but was unaware</p>	F 224			

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F 224	<p>Continued From page 4</p> <p>of any physical abuse toward residents. Resident #1 and Resident #2 had argued over clothing items. At times Resident #1 thought Resident #2 took his/her clothes. Continued interview revealed they both thought staff were only to separate them only when they had arguments. SRNA #1 stated the two (2) residents sit together for breakfast and lunch.</p> <p>Interview with SRNA #2, on 04/18/12 at 12:25 PM, revealed she had cared for both residents. Resident #1 had a history of being verbally and physically abusive towards staff. She was unaware of any incident of physical abuse toward Resident #2 and any intervention to keep them separated. They sat together at the lunch table and were allowed to be in their room together.</p> <p>Interview with Licensed Practical Nurse (LPN)/Unit Coordinator #1, on 04/18/12 at 3:00 PM, revealed on 04/02/12 Resident #2 reported Resident #1 had pinched her in the arm. Resident #2 had never reported this type of incident before. LPN #1 observed Resident #2's arm, where the resident said she was pinched, and noticed three (3) areas of petechia. Resident #2 stated it had happened the night before. Resident #1 recently had more episodes of being physically abusive towards staff. Interventions after the event was reported included an order for a lab to check for a urinary tract infection, the resident had a psychiatric evaluation on 04/06/12, and got an order on 04/07/12 for Risperdal (antipsychotic medication) 0.25 milligrams every AM and PM. They did not separate the residents after the event was reported because they were getting along.</p>	F 224		

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F 224	<p>Continued From page 5</p> <p>Interview with LPN #2 (evening charge nurse Unit One), on 04/18/12 at 5:25 PM, revealed Resident #1 and #2 had a history of fussing and arguing over clothes. LPN #2 stated she was aware of the incident where Resident #1 pinched Resident #2 because she read about in the chart. It had not been reported to her, but it should have been. Resident #1 was place on Risperdal after the event, but she was unaware of any other interventions. They do try to keep the resident separate, but this was in place prior to the incident.</p> <p>Interview with Social Services person, on 04/18/12 at 4:00 PM, revealed she was unaware of any arguments over items between Resident #1 and Resident #2, but this was something which should be reported to her. Resident #1 had a history of being physically and verbally abusive towards staff. She stated the Director of Nursing (DON) reported Resident #2 had stated Resident #1 had pinched him/her. They found a bruise where Resident #2 stated she had been pinched. She stated the event was discussed with the DON and Administrator and it was determined the event could have occurred. She stated staff was to keep the residents separated, it was included on the general care plan and the aide care plan to keep the residents separated. Continued interview revealed they were supposed to be separated even in the hallway.</p> <p>Continued interview with Social Services person, on 04/19/12 at 10:45 AM, revealed the intervention to keep Resident #1 and Resident #2 apart was a new intervention. When asked how staff was informed of the intervention, she stated the process was to notify the charge nurse. The</p>	F 224			

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F 224	Continued From page 6 charge nurse was supposed to relay the information to staff. It should have been on the care plan. After review of the care plan, she stated it should have been on the care plan. When informed of observations of residents observed being next to each other, she stated that should not have happened. Interview with the DON, on 04/19/12 at 12:30 PM, revealed she was aware of the incident between Resident #1 and Resident #2 and had recommended Resident #1 should be referred for a psychiatric evaluation and to check to see if a urine analysis should have been done (to check for a urinary tract infection). She stated she did not recall being informed of an intervention to keep the residents separated. If this was an intervention in place to protect the resident, staff should be made aware of it. The process was to inform the charge nurse. The care plan should have been updated to keep staff informed. Further interview revealed she did not feel like they effectively communicated all interventions listed as how they were going to protect the resident.	F 224			
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 facility's policy, it was determined the facility failed	F-226			

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F 226	<p>Continued From page 7</p> <p>to ensure policies and procedures established to prohibit mistreatment/abuse of residents had been implemented. A review of employee files revealed the facility failed to screen one (1) of five (5) sampled employees for a history of abuse in a timely manner. Employee #2 was hired on 04/04/12 and the abuse registry check was conducted on 01/23/12.</p> <p>The findings include:</p> <p>A review of the facility's policy: "Abuse, Neglect, and Exploitation, undated, revealed all potential employees will be screened for a history of abuse prior to employment. This includes checking with the appropriate licensing boards and registries.</p> <p>Interview with the Assistant Administrator, on 04/19/12 at 11:45 AM, revealed the facility's process for doing abuse registry checks was when a position was open and applications were received the facility did the abuse registry check for those they interviewed. The abuse registry checks were done within a short time period of the potential employee being hired to assure they were not on the abuse registry.</p> <p>A review of personnel files revealed the facility had hired Employee #2 on 04/04/12, for the position of State Registered Nursing Assistant (SRNA). However, based on documentation, the facility conducted the Nurse Aide Abuse Registry check on 01/23/12.</p> <p>Continued interview with the Assistant Administrator, on 04/19/12 at 12:05 PM, revealed the facility had performed an abuse registry check in January 2012 and the new hire was working at</p>	F 226	<p>An abuse check was re-run on 4-19-20 on Employee #2 finding the no evidence of abuse as prior abuse check showed.</p> <p>All employee records were checked by Paulette Hadden, front office employee, for timely abuse record checks.</p> <p>Quality Assurance department will run a second abuse check on day of orientation to have a double-checking system.</p> <p>Quality Assurance began a checklist of new hires displaying all items needed for the new hire folder. See attached. Also, quarterly in-services are being held to ensure abuse policy regulatory compliance.</p> <p>5-1-12</p>	

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F 226	Continued From page 8 another facility, at the time, so they did not think the employee would have been on the abuse registry. However, the time interval between the hire date and when the abuse registry check was performed was longer than their normal process based on records reviewed.	F 226	Nursing Assistant and Comprehensive Care Plan were updated on 4-19-12 by MDS Assistant, Social Services Director, and Assistant Director of Nursing to reflect interventions put into place. Staff in serviced one on one of additions on 4-20-12 by Unit Coordinator.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, review of the facility's Care Management policy and the facility's corrective actions (related to reported abuse event), it was determined the facility failed ensure the Comprehensive Plan of Care was	F 280	All care plans of residents with inappropriate behaviors were reviewed and revised if needed by Social Services and Quality Assurance Departments on May 10, 2012. Quality Assurance team will be given a copy of all reported behaviors for discussion purposes in order for appropriate communication to be relayed to unit staff for care plan updates and revisions. In-service was conducted on 4/27/12 by Director of Nursing to educate nurses on care plan additions and revisions. For those employees not able to attend the inservice, one on one education was completed by Director of Nursing as staff was scheduled to work. Quality Assurance will monitor for Care Plan revision during Quarterly care plans for inconsistencies. If any are noted, corrections will be put into care plans immediately. 5-11-12		

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F 280	<p>Continued From page 9</p> <p>revised for one (1) of three (3) sampled residents (Resident #1). The facility reported to the Office of Inspector General Resident #1 pinched Resident #2 on 04/02/12. Review of the corrective actions included an intervention to keep Resident #1 and Resident #2 apart. Review of the Comprehensive Care Plan and Aide Care Plan for Resident #1 revealed the facility failed to revise the care plans to include this intervention.</p> <p>The findings include:</p> <p>Review of the facility's policy: "Care Management", revealed under the section entitled "Policy" the plan of care was to be reviewed and revised to reflect current needs of the resident.</p> <p>Review of the facility's policy: "Nursing Assistant Care Plan", undated, revealed the Nurse Aide Care Plan was to be updated whenever there was a change in the care of the resident.</p> <p>Review of the medical record for Resident #1 revealed the resident was admitted by the facility, on 10/02/08, with diagnoses which included Anxiety, Depression, and Panic Attacks. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 02/08/12, revealed the resident was severely cognitively impaired. Further MDS review revealed the resident was assessed as having physical behavioral symptoms directed toward others (e.g., hitting, kicking, scratching, grabbing) and verbal behaviors towards others (e.g., threatening others, screaming at others, cursing at others).</p> <p>Review of the facility's report of a resident to</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>resident abuse incident submitted to the Office of Inspector General, dated 04/04/12, revealed Resident #1 had pinched Resident #2 on the left arm. The facility had performed a skin assessment on Resident #2 and the resident did have a bruise to his/her left arm. The corrective actions implemented by the facility included an intervention of staff keeping Resident #1 and Resident #2 apart.</p> <p>Interview with Social Services Person regarding the reported resident to resident abuse, on 04/18/12 at 4:00 PM, revealed they discussed the event and felt like it could have occurred. When asked about what interventions were implemented, she stated the facility staff were to try to keep the residents separated. She stated she thought the intervention to keep the residents separate was included on the comprehensive care plan and the nurse aide care plan.</p> <p>Record review of nurse's notes revealed periodic episodes of physically abusive behaviors as evidenced by the following nurse's note documentation: date 03/29/12 at 8:31 PM revealed resident was yelling; scratching, slapping, and kicking at staff; date 03/30/12 at 6:00 PM revealed the resident kicked nurse in leg, told the nurse she was going to punch her in face with her fist, and the resident was observed in hallway backing (wheelchair) into other residents and trying to roll over feet of other resident; date 03/31/12 at 3:55 PM resident was combative, hitting, scratching, kicking and kicked a female State Registered Nursing Assistant (SRNA) in the breast.</p> <p>Review of the Comprehensive Care Plan for</p>	F 280		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2012
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
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F 280	<p>Continued From page 11</p> <p>Resident #1 revealed no documented evidence the facility updated the care plan for behaviors. In addition, there was no documented evidence the care plan was revised to include the intervention of keeping Resident #1 separated from Resident #2. Review of the nurse aide care plan revealed it did not include an intervention to keep Resident #1 separated from Resident #2.</p> <p>Interview with SRNA #3, on 04/18/12 at 1:30 PM, revealed when Resident #1 and Resident #2 argue, they were to separate the residents at that time. If no problems were observed, as far as she knew, the residents could be together.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/18/12 at 3:00 PM, revealed she was aware of the episode where Resident #1 pinched Resident #2. She stated the resident was placed on Risperdal (behavior medication) after the event, and they got an order to check the resident for a urinary infection. They did not separate the residents after this was reported because the residents were getting along.</p> <p>Interview with State Registered Nurse Assistant (SRNA) #6, on 04/19/12 at 10:15 AM, revealed Resident #1 and Resident #2 got into arguments at times. Resident #1 got confused and upset because he/she thought Resident #2 got into his/her closet, but the resident did not. She stated she was unaware of any physically abusive episodes. She stated staff was supposed to keep them separate because of outbursts. Continued interview revealed keeping the residents apart was not in the care plan, they were just told.</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>Interview with Social Services, on 04/19/12 at 10:45 AM, revealed the intervention to separate Resident #1 and Resident #2 was not listed on Resident #1's comprehensive care plan or nurse aide care plan. Further interview revealed the intervention should have been included on both care plans.</p> <p>Interview with the Director of Nursing (DON), on 04/19/12 at 12:30 PM, revealed if there was a new intervention to keep the residents separated to protect the other resident, staff should be made aware of it. The process was to inform the charge nurse to alert staff and update the care plan. She further stated she did not feel like they effectively communicated all interventions as to how they were to protect the resident.</p> <p>Interview with the Quality Assurance person, on 04/19/12 at 1:40 PM, revealed the care plans should have been updated to ensure interventions were communicated to staff. The person responsible for making sure care plans were updated with the identified intervention failed to ensure they were updated according to the facility's process.</p>	F 280			