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

PRINTED: 08/24/2011
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
	185354		C 08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORDSVILLE NURSING AND REHABILITATION CENTER	313 MAIN STREET FORDSVILLE, KY 42343

(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
F 000	INITIAL COMMENTS Abbreviated surveys (KY #15807 and KY#16556) were conducted on 08/09/11 through 08/11/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "D." KY #15807 was substantiated with deficiencies cited related to the allegation. KY #16556 was unsubstantiated with no regulatory violations identified.	F 000		
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	F 225	F 225 1. On August 10, 2011 upon notification of the allegations of abuse, an investigation was immediately initiated. Interviews were conducted by the Social Service Director and the Regional Director of Clinical Services with Residents #5, #7, and #8. Since the alleged incident occurred in the smoking area, alternative smoke times were provided to Resident #5. Certified Nurse's Assistant #1 was suspended on August 10, 2011 pending completion of the investigation. Upon completion of the investigation, Certified Nurse's Assistant #1 employment was terminated.	8-12-11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA/RDO — (X6) DATE: 8-29-11

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 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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	185364		C 08/11/2011

NAME OF PROVIDER OR SUPPLIER: FORDSVILLE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 313 MAIN STREET, FORDSVILLE, KY 42343

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F 225	Continued From page 1 Investigation is in progress. The results of all investigations must be reported 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 observations, record review, review of facility policy/procedure and interviews, it was determined the facility failed to report complaints from two residents (#7 and #8), in the selected sample of eight (8), in regard to allegations of sexually inappropriate remarks and gestures made by another resident (#5.) The findings include: A review of the facility's policy/procedure for "Prevention and Reporting Abuse/Neglect," dated October 1999 and revised January/February 2011, revealed "staff members were to report allegations of abuse, neglect, mistreatment or misappropriation immediately to the Administrator and the Director of Nursing (DON) or designee. Immediately meant as soon as possible, but ought not to exceed 24 hours after the discovery of the incident, in the absence of a shorter state time frame requirement." A record review revealed Resident #5 was admitted on 12/31/01 with diagnoses to include a	F 225	2. On August 10, 2011 the Social Service Director, Assistant Director of Nursing, and the Regional Director of Clinical Services spoke with all interview able residents to determine if any other resident has ever been physically or verbally inappropriate towards them or witnessed any other resident being treated physically or verbally inappropriately by another resident. No other concerns were identified. On August 10, 2011 the Administrator, Director of Nursing, and the Education and Training Director conducted and interview of all employees to determine if they have ever witnessed a resident being physically or verbally inappropriate to another resident or if any resident has ever reported to them that another resident had been verbally or physically inappropriate towards them. No other concerns were identified. 3. Reeducated by the Education Training Director on policy and procedure for reporting abuse and neglect was immediately initiated on August 10, 2011 for all staff. Each staff member was reeducated prior to the beginning of their next scheduled shift and completed a post test to validate understanding on the policy and procedure for reporting abuse and neglect.	8-12-11

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F 225	Continued From page 2 Left Below the Knee Amputation (BKA), History of Cerebrovascular Accident (CVA) with left-sided weakness, Diabetes, Respiratory Failure, Chronic Obstructive Pulmonary Disease (COPD) and History of Schizoaffective Disorder, Paranoia, Psychosis and Personality Disorder. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/14/11, revealed Resident #5 required total assistance of two staff members with bed mobility and a hoyer lift for transfer. He/she was incontinent of bowel and bladder. A review of the care plan for "Mood and Behavior," dated 03/15/11 and reviewed 05/09/11, revealed the resident's behavior included cursing, yelling and threatening staff, hitting, throwing things, kicking and slapping the staff during care and sexually inappropriate behavior toward the staff. An observation of Resident #5, on 08/09/11 at 4:35 PM, revealed he/she was seated in a geri-chair in his/her room, with the right leg and a left BKA elevated with a lift sling. The resident's speech was rapid, mumbled, coarse, cursing and contained sexually inappropriate remarks toward the staff and other residents. An interview with Resident #8, on 08/09/11 at 11:06 AM, revealed "Resident #5 was always after Resident #7" and "spoke vulgar and filthy language." Resident #8 stated, "Resident #5 kicked him/her between the legs," to which Resident #8 stated, "he/she hit Resident #5 with a fly swat." Further interview revealed these behaviors, related to Residents #5, #7 and #8,	F 225	4. Department Managers will meet with their assigned residents weekly x 12 weeks to ensure any reported concern have been properly addressed. Administrator will attend Resident Council meetings monthly x 3 months to ensure all resident concerns are addressed timely through the concern process. Staff will be re-education monthly x 3 months on the policy and procedure for reporting abuse and neglect. All identified concerns will be reviewed by the Quality Assurance committee monthly. If at any time concerns are identified the Quality Assurance committee will analyze and implement further measures dependent upon the root cause to assure ongoing compliance.	8-12-11

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F 225	Continued From page 3 occurred during a smoke break. An observation of Resident #7, on 08/09/11 at 10:50 AM, revealed he/she was alert/oriented and seated in a wheelchair in his/her bedroom. An interview with Resident #7 revealed, "He/she (Resident #5) always tried to put his/her hands on me, tried to get me to go to bed with him/her and tried to put his/her foot on my legs." Resident #7 stated he/she reported the allegation to Certified Nurse Aide (CNA) #1, on 08/07/11, and was told by CNA #1, to report this information to the Administrator or the DON. The resident revealed he/she was unable to talk to the DON or Administrator at that time, as instructed by the CNA, as neither of them were in their office when the resident propelled himself/herself down the hallway. An interview with CNA #1, on 08/10/11 at 9:35 AM, revealed she "was made aware a few days ago that Resident #5 talked about wanting to have sex with Resident #7," and "Resident #7 did not want Resident #5 around;" however, the CNA, who assisted with residents during his/her smoke breaks, did not hear Resident #5 say anything to Resident #7. CNA #1 revealed she instructed Resident #7 to report this matter to the Administrator or the DON, "so they could correct it." CNA #1 revealed "this was a personal matter, and Resident #5 required assistance to get out of his/her bed." Interviews with Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #1, the Activity Director, CNAs #1 and #2, and Housekeeper #1, on 08/11/11, throughout the morning starting at 8:42 AM, until 12:08 PM, revealed Resident #5's	F 225		

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F 225	Continued From page 4 history included cursing, sexually inappropriate remarks and combativeness toward the staff. None of the staff were aware of Resident #5 displaying inappropriate behavior toward other residents. An interview with the Administrator and the DON, on 08/09/11 at 4:45 PM, revealed they were aware of Resident #5's history of being verbally/physically abusive and sexually inappropriate toward the staff; however, they were not made aware of Resident #5 acting out toward other residents, and this was a new behavior for the resident.	F 225		