

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

PRINTED: 11/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2011
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WOODSPOINT DRIVE FLORENCE, KY 41042
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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	INITIAL COMMENTS	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, BridgePoint Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 225 SS=D	<p>483.13(c)(1)(i)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225	<p>F225</p> <p>1. On 10-06-11, the Administrator conducted an investigation into an allegation of mistreatment regarding Resident #8. Resident #8 denies that he was hit by CNA #1 or any other staff member. The allegation was investigated and unsubstantiated by the Office of Inspector General on 10-28-11. CNA #1 no longer works at the facility as of 10/17/11.</p> <p>2. Current residents were interviewed by the Administrator on 11-18-11 to ensure there were no outstanding allegations of mistreatment/abuse. No other concerns were identified.</p>	11/19/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/23/11
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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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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 225	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, review of the facility's "Abuse Prohibition Policy", and review of the facility investigation, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse, or injuries of unknown source were reported to state agencies in accordance with state law. In addition, it was determined the facility failed to have an effective system to ensure all allegations of abuse, or injuries of unknown source were thoroughly investigated to ensure protection of residents from potential abuse while the investigation was in progress for one (1) of eight (8) sampled residents (Resident #8).</p> <p>An allegation of abuse was reported by Resident #8 involving Certified Nursing Assistant (CNA)#1. There was no documented evidence the facility protected the residents by thoroughly investigating the allegation and no documented evidence the allegation was reported to state agencies.</p>	F 225	<p>3. The Administrator and Director of Nursing were re-educated on reporting abuse, neglect and misappropriation to required state agencies on 11-16-11 by the Regional Director of Clinical Operations. Center staff have been re-educated by the Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers as of 11-18-11 regarding abuse, neglect, and misappropriation. If an allegation occurs, the Administrator or designee will complete a thorough investigation of the incident, notify the required state agencies and implement steps to protect the resident during the investigation. The Social Services Director will maintain a tracking log to ensure the investigations are conducted and state agencies are notified.</p> <p>4. The Administrator and or Director of Nursing will review the tracking log weekly and any allegation of abuse/neglect or misappropriation to determine that allegations have been investigated and reported to the required state agencies. A summary of findings will be presented monthly times 3 months to the Performance</p>	
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F 225	<p>Continued From page 2 The findings include:</p> <p>Review of the facility's "Abuse Prohibition Policy", dated 12/25/11, revealed a full investigation would always occur, and employees would be suspended pending investigation if the allegation was for abuse/neglect. Further review revealed all reports would be called and faxed into Community Based Services and Office of Inspector General, Division of Long Term Care, immediately and called to the local police department if warranted. Interview with the Administrator, on 10/27/11 at 4:30 PM, revealed this was the current facility Abuse Policy.</p> <p>Review of Resident #8's clinical record revealed diagnoses which included Dementia, Depression, Dysphagia requiring a Gastric Tube, and Cerebral Vascular Disease (CVA) with left hemiparesis. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/26/11 revealed the facility assessed the resident as having severe cognitive impairment. Further review revealed the facility assessed the resident as requiring total assistance with all Activities of Daily Living (ADL's).</p> <p>Review of the Comprehensive Plan of Care dated 09/01/11, revealed the resident exhibited inappropriate behavior, refused treatment and care at times, and was combative with staff and family. The interventions included reapproaching resident when he/she was calm if the resident refused care.</p> <p>Review of the facility's investigation, dated 10/06/11 and conducted by the Administrator, revealed the facility could not substantiate that</p>	F 225	<p>Improvement Committee for review and further recommendation.</p> <p>Date of Compliance 11-19-11</p>	
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F 225	<p>Continued From page 3</p> <p>Certified Nursing Assistant (CNA) #1, the alleged perpetrator, made any contact with Resident #8. "This is an accident where tube feed pole fell on resident when bed was lowered". Further review revealed Resident #8 confirmed on three (3) occasions that CNA #1 did not touch or strike him/her. Continued review revealed the Director of Nursing (DON) and the Administrator re-enacted the sequence of events and described and found statements consistent with re-enactment. Further review of the investigation revealed statements were obtained from CNA #1 and Resident #8 and both parties denied any abuse. There was no documented evidence of statements from other staff working at the time of the incident. Review of CNA #1s Time Card revealed the CNA clocked out on 10/06/11 at 3:00 AM and clocked back in to work on 10/06/11 at 3:00 PM.</p> <p>Interview with the Administrator, on 10/27/11 at 4:10 PM, revealed Licensed Practical Nurse (LPN) #2 called him at home at 1:30 AM on 10/06/11 and stated Resident #8 was bleeding in the face and he did it (referring to CNA #1, alleged perpetrator). He further stated he instructed LPN #2 to remove CNA #1 from the facility, obtain a statement from the resident, and conduct a head to toe assessment of the resident. Continued interview revealed LPN #2 stated CNA #1 told her the tube feeding pole fell on Resident #8, but she did not believe there was any way that happened. The Administrator stated he came in on 10/06/11 and asked Resident #8 three (3) different times if CNA #1 had hit him/her and the resident denied it. Further interview revealed CNA #1 said the resident moved his/her paralyzed arm with his/her good arm and the tube</p>	F 225		
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F 225	<p>Continued From page 4</p> <p>feeding tubing was wrapped around his/her arm causing the tube feeding pole to turn over when the bed was lowered. The Administrator stated, based on his investigation this was an accident.</p> <p>Interview on 10/27/11 at 4:50 PM with LPN #2 revealed she was working another unit when LPN #3 called and told her Resident #8 got hit. She stated she checked on the resident and noted three (3) open areas to the face. She stated she cleaned the resident's face and asked the resident what happened. She stated the resident said, "he hit me", but he did not know what he/she was hit with. She stated CNA #1 was the only male on the floor. She further stated the resident could talk clearly and express his/her needs but had a memory deficit. She called the Administrator who told her to take CNA #1 into Resident #8's room and take LPN #4 as a witness to find out what happened. She stated she asked CNA #1 what happened and he said he raised the bed up to do his/her care then walked around the bed to use the control to lower the bed. The resident had the tubing wrapped around his/her left arm, and used his/her right arm to lift the paralyzed left arm and when CNA #1 lowered the bed the pump fell over. She stated she wrote down what CNA #1 said and CNA #1 read it and signed it. She further stated she had CNA #1 go to the break room which was downstairs away from the resident care areas until the bus could come for him. She stated she gave the statement to the DON or Administrator the next morning.</p> <p>Interview, on 10/28/11 at 2:00 PM, with LPN #4 revealed she went in Resident #8's room as a witness while LPN #2 interviewed CNA #1 and</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>Resident #8. She stated CNA #1 said he was lowering the bed when Resident #8 reached over and lifted the left arm with the right hand which pulled the tube feeding tubing and pulled the tube feeding pole over. She stated Resident #8 said nothing while CNA #1 made the statement. Further interview revealed when CNA #1 left the room, the resident told her he/she did not want CNA #1 to lose his job, but something hit him/her and it was not the tube feeding pole.</p> <p>Interview, on 10/28/11 at 10:00 AM, with LPN #3 revealed she was the nurse assigned to Resident #8 on 10/06/11, and at 2:15 AM CNA #1 came to her and explained Resident #8 had pulled the tube feeding pole over on him/herself and she may need to come and check the resident. She stated she immediately went into Resident #8's room and noted there were three (3) facial injuries. She further stated there was an L shaped laceration to the left cheek, a circular abrasion to the bridge of the nose and a larger abrasion to the left nare. She stated she asked Resident #8 what happened and he/she stated, "He hit me, that's what happened". She stated she pointed to the tube feeding pole and asked if that was what hit him/her and the resident stated "no, he had something in his hand, not sure what he hit me with". She stated CNA #1 was on the other side of the room during the conversation. She further stated, she then asked CNA #1 to leave the room and she went to get LPN #2 and LPN #4. Further interview revealed the nurses called the Administrator while she started a neurological assessment. She stated she notified the resident's spouse of the facial injuries and notified the Physician to obtain a treatment for the facial injuries. She further stated, although</p>	F 225		
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F 225	<p>Continued From page 6</p> <p>Resident #8 had a diagnosis of Dementia, the resident knew what he/she was saying for the most part. Continued interview revealed the Director of Nursing (DON) and the Administrator interviewed her and read her statement.</p> <p>Interview, on 10/28/11 at 6:30 PM, with the DON revealed the Administrator called her and she met him at the facility on 10/06/11. She stated she went with the Administrator to interview Resident #8 and the Administrator asked the resident several times if CNA #1 had hit him/her and the resident denied it. She further stated she and the Administrator spoke with LPN #3 who was assigned to the resident at the time of the incident, and she explained CNA #1 had told her the tube feeding pole fell on Resident #8 and he/she was bleeding. Continued interview revealed LPN #3 stated she knew CNA #1 did it because she knew him. The DON stated LPN #3 did not tell them she had interviewed Resident #8 and therefore she was unaware Resident #8 had alleged CNA #1 had hit him/her. Further interview with the DON revealed she did not interview any other staff.</p> <p>Interview was attempted with Resident #8 on 10/28/11 at 3:00 PM, however the resident refused to speak with the surveyor.</p> <p>Interview was attempted by phone with CNA #1, on 10/28/11 at 11:00 AM; however, was unsuccessful.</p> <p>Further interview with the Administrator, on 10/28/11 at 7:00 PM, revealed he did not agree this was an allegation of abuse because it was not substantiated by the resident. He stated he</p>	F 225		

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F 225	Continued From page 7 did direct LPN #2 to obtain a statement from Resident #8; however, he did not have the statement and was unaware of what the statement said. He stated, he obtained statements from CNA #1 and Resident #8 and that satisfied the investigation because they were the only individuals in the room at the time of the incident and their stories were consistent. He stated he did not remember conducting interviews with other staff and did not remember asking staff to write statements related to the incident. He further stated he was unaware of Resident #8 telling LPN #2 and LPN #3 that he/she was hit by CNA #1 because he had not interviewed the nurses. When asked if the residents were protected if a thorough investigation was not completed, he stated "no, I don't, but in this instance I think the investigation was thorough for the situation, filtering out opinions of staff who did not like CNA #1. Continued interview revealed if there was an allegation of abuse, the facility was to report the allegation within twenty-four (24) hours; however, he did not call the incident in to state agencies because through his investigation he did not consider it an allegation of abuse, but considered it an accident.	F 225		
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, clinical record review, review	F 226		

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F 226	<p>Continued From page 8 of the facility's "Abuse Prohibition Policy", and review of the facility's investigation, it was determined the facility failed to implement their "Abuse Prohibition Policy" regarding protecting residents after an allegation of abuse was received, thoroughly investigating the alleged abuse, and reporting the alleged abuse to the appropriate state agencies for one (1) of eight (8) sampled residents (Resident #8).</p> <p>Resident #8 made an allegation of abuse towards Certified Nursing Assistant (CNA) #1, however, there was no documented evidence a thorough investigation was completed and no documented evidence state agencies were notified of the allegation.</p> <p>The findings include:</p> <p>Review of the facility "Abuse Prohibition Policy", dated 12/25/11, revealed a full investigation would always occur, and employees would be suspended pending investigation if the allegation was for abuse/neglect. Further review revealed all reports would be called and faxed into Community Based Services and Office of Inspector General, Division of Long Term Care, immediately and called to the local police department if warranted. Interview with the Administrator on 10/27/11 at 4:30 PM revealed this was the current facility Abuse Policy.</p> <p>Review of Resident #8's medical record revealed diagnoses which included Dementia, Depression, Dysphagia requiring a Gastric Tube, and Cerebral Vascular Disease (CVA) with left hemiparesis. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/26/11 revealed</p>	F 226	<p>F226</p> <ol style="list-style-type: none"> 1. Resident #8 was re-assessed on 10/17/11 by the Director of Nursing with no findings. CNA #1 no longer works at the facility as of 10/17/11. 2. Current residents were interviewed by the Administrator on 11-18-11 to ensure there were no outstanding allegations of mistreatment/abuse. No other concerns identified. 3. The Administrator and Director of Nursing were re-educated to the Abuse Prohibition Procedure on 11-16-11 by the Regional Director of Clinical Operations. Center staff have been re-educated by the Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers as of 11-18-11 regarding the Abuse Prohibition Procedure. If an allegation occurs, the Administrator or designee will complete an investigation of the incident, notify the required state agencies and implement steps to protect the resident during the investigation. The Social Services 	11/19/11
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F 226	<p>Continued From page 9</p> <p>the facility assessed the resident as having severe cognitive impairment and as requiring total assistance with all Activities of Daily Living (ADL's).</p> <p>Review of the facility investigation conducted by the Administrator, dated 10/06/11, revealed the facility could not substantiate Certified Nursing Assistant (CNA) #1, alleged perpetrator making any contact with Resident #8. "This is an accident where tube feed pole fell on resident when bed was lowered". Further review of the investigation revealed Resident #8 confirmed on three (3) occasions that CNA #1 did not touch or strike him/her. Continued review revealed statements were obtained from CNA #1 and Resident #8 and both parties denied any abuse. There was no documented evidence of statements from other staff working on the unit at the time of the incident.</p> <p>Interview, on 10/27/11 at 4:10 PM, with the Administrator revealed Licensed Practical Nurse (LPN) #2 called him at home at 1:30 AM on 10/06/11 and explained Resident #8 was bleeding in the face and he did it (referring to CNA #1, alleged perpetrator). He stated, he instructed LPN #2 to remove CNA #1 from the facility, obtain a statement from the resident, and conduct a head to toe assessment of the resident. Further interview revealed LPN #2 stated CNA #1 told her the tube feeding pole fell on Resident #8; however, she did not believe there was any way that could have happened. The Administrator stated he came in on 10/06/11 and asked Resident #8 three (3) different times if CNA #1 had hit him/her and the resident denied it each time. Continued interview revealed CNA #1 said</p>	F 226	<p>Director will maintain a tracking log to ensure the investigations are conducted and state agencies are notified.</p> <p>4. The Administrator and or Director of Nursing will review the tracking log weekly and any allegation of abuse/neglect or misappropriation to determine that allegations have been investigated and reported to the required state agencies. A summary of findings will be presented monthly times 3 months to the Performance Improvement Committee for review and further recommendation.</p> <p>Date of Compliance 11-19-11</p>	
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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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 226	<p>Continued From page 10</p> <p>the resident moved his/her paralyzed arm with his/her good arm and the tube feeding tubing was wrapped around his/her arm causing the tube feeding pole to turn over when the bed was lowered. The Administrator stated, he felt this was an accident based on his investigation.</p> <p>Interview with LPN #2 on 10/27/11 at 4:50 PM revealed she was working another unit when LPN #3 called explained Resident #8 got hit. She stated she assessed the resident and noted three (3) open areas to the face. She asked the resident what happened and the resident stated, "he hit me", but he did not know what he/she was hit with. She further stated CNA #1 was the only male on the floor. Continued interview revealed she called the Administrator who told her to take CNA #1 into Resident #8's room and take LPN #4 as a witness to find out what happened. She stated she asked CNA #1 what happened and he said he raised the bed up to do care then walked around the bed to use the control to lower the bed. The resident had the tube feeding tubing wrapped around his/her left arm, and used his/her right arm to lift the paralyzed left arm and when CNA #1 lowered the bed the pump fell over. She stated she wrote CNA #1 statement and had him sign it, then had CNA #1 go to the break room which was downstairs away from the resident care areas until the bus could come for him. She stated she gave the statement to the Director of Nursing (DON) or Administrator the next morning.</p> <p>Interview, on 10/28/11 at 2:00 PM, with LPN #4 revealed she went in Resident #8's room while LPN #2 interviewed CNA #1 and Resident #8. She stated CNA #1 said he was lowering the bed when Resident #8 reached over and lifted the left</p>	F 226		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2011
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 226	<p>Continued From page 11</p> <p>arm with the right hand which pulled the tube feeding tubing and pulled the tube feeding pole over. She further stated Resident #8 said nothing while CNA #1 made the statement, Continued interview revealed when CNA #1 left the room, the resident told her he/she did not want CNA #1 to lose his job, but something hit him/her and it was not the tube feeding pole.</p> <p>Interview, on 10/28/11 at 10:00 AM, with LPN #3 revealed she was the nurse assigned to Resident #8 on 10/06/11, and at 2:15 AM CNA #1 informed her Resident #8 had pulled the tube feeding pole over on him/herself and she may need to check the resident. She stated she immediately entered Resident #8's room and noted there were three (3) facial injuries. She described the injuries as an L shaped laceration to the left cheek, a circular abrasion to the bridge of the nose and a larger abrasion to the left nare. Continued interview revealed she asked Resident #8 what happened and he/she stated, "He hit me, that's what happened". She stated she pointed to the tube feeding pole and asked if that was what hit him/her and the resident stated "no, he had something in his hand, not sure what he hit me with". She stated CNA #1 was on the other side of the room during the conversation. She then asked CNA #1 to leave the room and she went to get LPN #2 and LPN #4. Further interview revealed the nurses called the Administrator while she started a neurological assessment. She notified the resident's spouse of the facial injuries and notified the Physician to obtain a treatment for the facial injuries. She stated, although Resident #8 had a diagnosis of Dementia, the resident knew what he/she was saying for the most part. Continued interview revealed the DON</p>	F 226		
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPRING DRIVE FLORENCE, KY 41042
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F 226	<p>Continued From page 12 and the Administrator interviewed her and read her statement regarding the incident.</p> <p>Interview on 10/28/11 at 6:30 PM with the DON, revealed the Administrator called her and she met him at the facility early on 10/06/11. She stated she went with the Administrator to interview Resident #8 and the Administrator asked the resident several times if CNA #1 had hit him/her and the resident denied it each time. She further stated she and the Administrator spoke with LPN #3 who was assigned to the resident at the time of the incident, and she explained CNA #1 had told her the tube feeding pole fell on Resident #8 and he/she was bleeding. Further interview revealed LPN #3 stated she knew CNA #1 did it because she knew him. The DON stated LPN #3 did not tell them she had interviewed Resident #8 and therefore she was unaware Resident #8 had alleged CNA #1 had hit him/her. Continued interview with the DON revealed she did not interview any other staff.</p> <p>Interview was attempted with Resident #8 on 10/28/11 at 3:00 PM, however the resident did not wish to speak with the surveyor.</p> <p>Interview was attempted by phone with CNA #1 on 10/28/11 at 11:00 AM; however, the CNA could not be reached.</p> <p>Further on 10/28/11 at 7:00 PM interview with the Administrator revealed he did not agree this was an allegation of abuse because it was not substantiated by the resident. He stated he did direct LPN #2 to obtain a statement from Resident #8; however, he could not find the statement and was unaware of what the</p>	F 226		

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F 226	<p>Continued From page 13</p> <p>statement said. He stated, he obtained statements from CNA #1 and Resident #8 which satisfied the investigation because they were the only individuals in the room at the time of the incident and their stories were consistent. He further stated he did not remember conducting interviews with other staff or asking staff to write statements related to the incident. Further interview revealed he was unaware of Resident #8 telling LPN #2 and LPN #3 that he/she was hit by CNA #1 because he had not interviewed the nurses. The Administrator was asked if the residents were protected if a thorough investigation was not completed, and he stated "no, I don't, but in this instance I think the investigation was thorough for the situation, filtering out opinions of staff who did not like CNA #1. Further interview revealed if there was an allegation of abuse, the facility was to report the allegation to state agencies within twenty-four (24) hours. However, he stated he did not report the incident because through his investigation he did not consider it an allegation of abuse, but considered it an accident.</p>	F 226		