

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

PRINTED: 08/10/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
(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 An abbreviated survey (KY #18787) was conducted on 07/26/12 through 07/27/12 to determine the facility's compliance with Federal requirements. KY #18787 was substantiated with deficiencies cited.	F 000	<i>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.</i>	
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, review of the facility's policy and procedure on Abuse Prohibition, and the Final Report of investigation, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit abuse of residents for one resident (#10), in the selected sample of three residents. The facility failed to ensure that staff immediately reported incidents of abuse to Administration in order to ensure that perpetrators were removed from direct patient care. On 07/13/12, State Registered Nurse Aide (SRNA) #1, #2, #3, and Certified Occupational Therapy Assistant/Licensed (COTA/L) witnessed an incident where Certified Medication Technician (CMT) #1 was allegedly being verbally abusive to Resident #1. However, these staff failed to report the allegation immediately to their supervisor. This failure to report the abuse allegation immediately allowed the alleged perpetrator to continue providing direct care to residents of the	F 226	1. CMT #1 was removed from patient care, 7/13/2012 at 9:00 AM. Subsequent investigation resulted in verification of inappropriate response by CMT to resident and CMT was terminated. On 7-13-12 DON re-educated staff on the Abuse Protocol and responsibility to report any suspected abuse immediately. 2. Facility staff interviews were conducted by DON / ADON on 7/13/2012 to determine if other employees had witnessed any act of abuse / neglect by another employee towards residents and the timeliness of reporting. DON/ADON will review all reports of suspected abuse for last 3 months to determine if there were delays in reporting noted so re-education with the reporter can occur one on one. This will be completed by 8-17-12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Clark TITLE: Administrator (X6) DATE: 8-15-12

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 226	Continued From page 1 facility as CMT #1 returned to the medication cart and passed medications before being removed from the floor by the Director of Nursing (DON) approximately 15 minutes later. The findings include: A review of the facility's policy and procedure on Abuse Prohibition, dated 02/05/03, revealed any incident of abuse or suspected abuse must be reported immediately to the available charge staff person. In addition, any individual suspected of causing abuse is to be removed from direct patient care and reassigned non-patient care duties or suspended from duty until an investigation is completed and a decision is made by the administrator of the facility. A review of the Final Report of the investigation, dated 7/18/12, revealed the facility received an allegation that Resident #1 was verbally abused by CMT #1 on 07/13/12. The allegation was made by SRNA #1. An interview with the COTA/L, on 07/26/12 at 2:28 PM, revealed she witnessed an incident of verbal abuse on 07/13/12 between CMT #1 and Resident #1. She stated she was sitting at a table on the opposite side of the dining room when she heard CMT #1 state "I wish you would stop, you are getting on my last nerve". CMT #1 left the dining room after a verbal exchange with SRNA #1. An interview with SRNA #3, on 07/26/12 at 3:08 PM, revealed she witnessed an incident of verbal abuse on 07/13/12 between Resident #1 and CMT #1. She stated she was sitting at the	F 226	<i>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.</i> 3. An in-service for nursing staff was conducted, 7/13/2012 by DON regarding the facility Abuse policy with emphasis on the responsibility of reporting suspected abuse immediately. All staff to be re-educated by 8-24-12 on facility Abuse Policy, this will be completed by DON or Administrator. The education will be repeated monthly for 3 months then quarterly for one year. Newly hired employees will receive this education during orientation. 4. Facility Corporate Consultant will review all reports of suspected abuse with the facility Administrator and DON to ensure the facility abuse policy is being followed. Findings will be presented to facility QA committee no less than quarterly X 1 year to ensure compliance with the policy. 5. Date of completion:	8-25-2012	

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F 226	<p>Continued From page 2</p> <p>opposite end of the table from the incident but observed SRNA #1 stand up and tell CMT #1 to leave and she would finish feeding Resident #1. SRNA #3 stated SRNA #1 finished feeding Resident #1.</p> <p>An interview with SRNA #2, on 07/27/12 at 10:26 AM, revealed she could hear the incident of verbal abuse on 07/13/12 between Resident #1 and CMT #1. She stated she was sitting at another table with residents in front of her. Resident #1 and CMT #1 turned with their backs to her at the next table over, but she could hear CMT #1 telling the resident to stop touching her. Then SRNA #1 got up and told CMT #1 to leave and she would finish feeding Resident #1. SRNA #2 stated SRNA #1 finished feeding Resident #1 before leaving the dining room.</p> <p>An interview with SRNA #1, on 07/26/12 at 2:47 PM, revealed she witnessed the incident of verbal abuse on 07/13/12 between Resident #1 and CMT #1. SRNA #1 revealed she told CMT #1 to leave the dining room and she would take over feeding Resident #1. SRNA #1 stated she completed feeding Resident #1 before going to the DON to report the incident approximately 10 minutes later.</p> <p>A phone interview with CMT #1, on 7/27/12 at 12:29 PM, revealed she was feeding Resident #1 and he/she kept grabbing her arm. She stated she told him/her to stop touching her several times and had moved his/her hand back to his/her lap multiple times. CMT #1 stated her voice is loud and she was not feeling well so it came out worse than intended. She stated SRNA #1 asked if she would like her to take care</p>	F 226		

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F 226	<p>Continued From page 3</p> <p>of him/her and she went back to the medication cart to pass medications. CMT #1 stated she passed medications to three or four residents before the DON came and took her to the office. She stated she was sent home at approximately 9:00 AM on 7/13/12 and was terminated by phone between 2:30 PM and 3:30 PM that afternoon.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 07/27/12 at 4:02 PM, revealed she was working on the hallway next to the dining area but did not hear anything and was not notified by staff of any incident in the dining room that morning. She stated she first learned about the incident when notified by the DON of the investigation.</p> <p>An interview with Registered Nurse (RN) #1, on 07/27/12 at 4:15 PM, revealed she was working on the hall where the incident occurred but was not notified by staff. She stated she learned of the incident after the investigation started. She stated she would have expected the staff to come get her as soon as the incident occurred so she could have taken CMT #1 to the office for the investigation to start.</p> <p>An interview with the DON, on 07/27/12 at 2:58 PM, revealed SRNA #1 came to her office to report the incident and she went to the floor to suspend CMT #1 pending the investigation. The DON stated the incident was not reported immediately because the SRNA finished feeding Resident #1 before coming to office about ten minutes after the incident. She stated the CMT #1 was removed from Resident #1 but admitted CMT #1 still had contact with residents until she was suspended and removed from the building. Therefore, the facility did not ensure that staff</p>	F 226		

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F 226	Continued From page 4 reported timely all allegations of abuse to administration which allowed an alleged perpetrator to still have direct contact with residents of the facility. CMT #1 was sent home on 7/13/12 pending the investigation and terminated later the same day. However, there was no information on the final report regarding the delayed reporting by SRNA #1.	F 226		