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

PRINTED: 09/06/2012
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
	185322		C 08/22/2012

NAME OF PROVIDER OR SUPPLIER: ROSE MANOR HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3057 NORTH CLEVELAND ROAD, LEXINGTON, KY 40516

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F 000	INITIAL COMMENTS	F 000		
	An abbreviated survey investigating KY#00018935 was conducted 08/20/12 through 08/22/12. KY#00018935 was substantiated with a related deficiency cited.			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		
	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.		F 226 Immediate Corrective Action: The facility interviewed the staff member who reported the allegation of abuse as well as SRNA#1, and the charge RN. The facility determined SRNA#1 failed to provide needed care for resident #1 resulting in mistreatment by neglect. The facility also determined that resident #2 was denied a request for assist resulting in a violation of resident rights. SRNA # 1 was terminated on 08-06-12 the reported allegation and facility investigation was submitted to APS and OIG. Other Residents Potentially Affected: All residents have the potential to be affected when the facility fails to take immediate action that ensures all residents are protected from potentially abusive staff.	
	This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure it was determined the facility failed to implement their abuse policy procedures to protect residents from potential further abuse and failed to immediately report two (2) allegations of abuse for two (2) of three (3) sampled residents (Resident #1 and Resident #2). Facility staff failed to immediately report two (2) allegations of abuse to their Director on Nursing (DON) and Administrator for notification to state agencies. On 08/04/12, State Registered Nursing Assistant (SRNA) #1 was overheard telling Resident #2, who requested to be toileted, to go ahead and pee in his/her brief. It was also alleged SRNA #1 did not provide care to Resident #1 during their shift. The Director of Nursing and Administrator were not made aware of the abuse allegation until the morning of 08/06/12 and failed to notified the proper state agencies until 08/06/12 of the alleged abuse.			

RECEIVED SEP 12 2012 BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alfred G. McGregor — TITLE: C.E.O. — (X6) DATE

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 ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	

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F 226	Continued From page 1	F 226		

The findings include:

Review of the facility's policy titled: "Abuse Program Policy and Procedure", undated, revealed it was the policy of the facility to maintain an environment free of abuse and neglect. Review of the policy procedures revealed: Section #4, All staff will receive training on what constitutes abuse, neglect, and misappropriation of property; Section #9, If abuse was suspected a report would be made immediately to Adult Protective Services and Licensing and Regulations; Section #11, If a resident was subjected to have been abused by facility staff, the staff person would be suspended until all investigations were concluded.

Interview with the Administrator, on 08/22/12 at 5:00 PM, revealed staff was supposed to report any allegations of abuse immediately up the chain of command. Staff accused of abuse should be suspended immediately per their policy.

1. Review of Resident #1's Medical Record revealed the resident was admitted to the facility on 06/11/12 and had diagnoses which included Alzheimer's Disease and History of Delirium. Review of the Admission Minimum Data Set (MDS) Assessment, dated 06/22/12 revealed the resident was frequently incontinent of bowel and bladder.

Review of Resident #1's Care Plan revealed the resident was care planned for self care deficit due to loss of function and awareness and had an intervention of total assistance of staff for all care. The resident was also care planned for alteration

Systematic Changes: A review of the facility policy and procedure for abuse was implemented by the Asst.Adm. , DON, and the QA Nurse. Revision of the facility requirements regarding abuse reporting was made. A mandatory in-service was held on 08-27-12. The abuse policy and procedure was reviewed with staff. All staff was instructed of reporting requirements (see addendum) that include immediate reports by the charge staff as well as the staff member reporting the allegation. The staff was required to sign to acknowledge the revised reporting requirement. This will be included as part of new hire/agency training and orientation. Contact numbers for the Asst Adm., DON, and the QA Nurse are now posted on the staff bulletin board to assure access.

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F 226	Continued From page 2	F 226		

in bowel and bladder function and included interventions for pads/briefs and assistance for hygiene. Further review of the care plan revealed the resident's Care Plan was updated on 07/30/12 for a Stage II Pressure Ulcer to the Coccyx and had as an intervention to turn and reposition the resident every two hours. Review of the Aide Flow Sheet revealed the resident was supposed to be positioned every two hours.

Interview with SRNA #6, on 08/21/12 at 2:05 PM, revealed Resident #1 was incontinent and was supposed to be checked at least every two hours for incontinence of bladder and/or bowel. In addition, the resident was supposed to be repositioned every two hours. On 08/04/12, evening shift, SRNA #1 was caring for Resident #1, but SRNA #6 assisted the resident with his/her dinner meal and had put the resident's bed in an upright position for the meal. Further interview revealed at about 10:00 PM, when finishing rounds, SRNA #6 went into the resident's room to help SRNA #1 and the resident's bed was still in the upright position and the resident was slumped over in the bed. SRNA #6 questioned SRNA #1 about the resident being in same position as at dinner time and SRNA #1 rolled her eyes. Further interview with SRNA #6 revealed when they were changing the resident the brief and pad were soaked with urine and feces. The SRNA informed Registered Nurse (RN) #1 of her suspicions about the resident being neglected.

Interview with SRNA #1, on 08/22/12 at 12:35 PM, revealed she had checked on Resident #1 a couple of times during her shift and the resident was not wet so she did not change the brief, but

Monitoring: Compliance will be assured by the Quality Assurance team. The Asst Adm will submit a review per the Employee Screening Record at monthly QA meetings. This review assures all required new hire documents (see addendum) are completed.

Completed: 09-11-12

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did reposition the resident. She stated she did rounds about every two (2) hours and checked on the resident.

Interview with SRNA #2, on 08/22/12 at 12:55 PM, revealed she went into Resident #1's room at 10:30 PM and heard SRNA #6 talking to SRNA #1, saying the Resident was still up from supper. SRNA #2 further revealed at about 10:50 PM, SRNA #1 told SRNA #2 she had not touched the resident all day.

Interview with RN #1, on 08/21/12 at 5:20 PM, revealed she she was told by the Director of Nursing (DON), on 08/06/12, it was reported that SRNA#1 had not changed Resident #1. RN #1 stated on 08/18/12 she had seen SRNA #1 going in and out of Resident #1's room and assumed the resident was being changed. RN #1 also stated she had assessed the resident's pressure area during her shift and the resident was not wet at that time. The RN also stated the resident was in different positions when she was making rounds.

Interview on , 08/22/12 at 5:00 PM, with the Assistant Administrator revealed they determined the incident involving Resident #1 to be abuse because the SRNA #1 told another SRNA she provided no care to the resident that shift. It was neglect because the SRNA failed to provide the care that was needed.

2. Review of Resident #2's Medical Record revealed the facility admitted the resident on 02/22/08 with diagnoses which included Alzheimer's Dementia, Functional Decline and a history of Urinary Tract Infection. Review of the

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F 226	Continued From page 4 Quarterly MDS Assessment, dated 06/04/12, revealed the resident was cognitively impaired and was occasionally incontinent of bowel and bladder. Review of the plan of care revealed staff was to toilet the resident when rounding and as needed. The resident was also to wear briefs/pull-ups. Interview, on 08/21/12 at 2:05 PM, with SRNA #6 revealed Resident #2 was supposed to be taken to the toilet when requested and when making rounds. The resident had accidents and wore a brief. She further stated while making rounds, on 08/04/12 at around 7:00 PM, she overheard SRNA #1 telling the resident to just pee. When SRNA #6 came into the room to see if she could help, the resident was not on the toilet and SRNA #1 told SRNA #6, she had other things to do and the resident had a brief on. SRNA #6 told SRNA #1 the resident had the right to go to the bathroom. Further interview revealed she thought this was abuse and informed RN #1 after putting the resident on the toilet. Interview, on 08/22/12 at 12:35 PM, with SRNA #1 revealed Resident #2 wore briefs and she thought they were to be used for for the resident to go to the bathroom. On 08/04/12 she was getting Resident #2 ready for bed and was going to change his/her brief when the resident stated he/she had to pee. SRNA #1 stated she told the resident to go pee in the brief. She stated she thought it was okay since the resident had on the briefs. The RN came into the room and told her if the resident could go to the bathroom she needed to take him/her to the bathroom. She further stated,in looking back at it, she should have taken	F 226		

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F 226	Continued From page 5 the resident to the bathroom and should not have told him/her that. Interview, on 08/21/12 at 5:20 PM, with RN #1 revealed she was doing rounds at about 9:00 PM on 08/04/12 and heard SRNA #1 taking loudly to Resident #2 telling him/her to go to the bathroom in his/her diaper. The RN went into the room and told the SRNS she could not talk to the resident that way and it was the resident's right to be taken to the bathroom. This was the resident's room. RN #1 stated she then took the resident to the bathroom. Further interview with RN #1 revealed at the time she did not really think of the incident as abuse, but after talking to the DON about the event, she realized it was abuse and per the facility's abuse policy she should have pulled SRNA #1 off the floor and called the DON. Interview, on 08/22/12 at 4:15 PM, with DON revealed abuse should be reported immediately up the chain of command. Direct care staff was supposed to tell the Charge Nurse who would call the DON and or Administrator. An investigation would be started immediately. If an employee was suspected of abuse they were to be suspended immediately upon learning of the allegation. When asked about the alleged incident of an employee telling a resident to pee in their brief, the DON stated this was abuse. The SRNA should have taken the resident to be toileted because it was the resident's right to be toileted. The DON would consider this verbal abuse and neglect. She further stated when the nurse became aware of the incident she should have called the DON immediately, she was trained to do that. SRNA #1 should not have continued to work. SRNA #1 and the same RN	F 226		

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F 226	Continued From page 6 also worked the next day (08/05/12). The DON was notified about the event the morning of 08/06/12, by SRNA #6. Continued interview, on 08/22/12 at 5:00 PM, with the Assistant Administrator revealed the Charge Nurse should have reported the event immediately to the DON. She felt like SRNA #6, who reported an allegation of abuse to the RN, followed the chain of command. RN #1 failed to suspend SRNA #1 immediately. RN #1 should have suspended SRNA #1 immediately as soon as there was an allegation of abuse.	F 226		