

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

PRINTED: 07/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/21/2011
NAME OF PROVIDER OR SUPPLIER  HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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F 000	INITIAL COMMENTS	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
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 observation, interview, record review and review of "Facility Protocol for Reporting Suspected Resident Abuse", it was determined the facility failed to follow their policy/protocol for reporting and investigating allegations of abuse for two (2) of three (3) sampled residents (#1 and #2).  The findings include:  Review of the "Facility Specific Protocol for Reporting of Suspected Resident Abuse/Neglect", not dated, regarding Reporting and Response, included: Always report abuse immediately to the charge nurse and administration....an incident needs to be written and include all names of staff members working on the unit that shift. Identification should include immediately reporting any incident to the charge nurse, and removing any individual suspected of causing abuse from direct care and reassigned	F 226	Allegations of abuse were investigated by the OIG on 7/21/11 and they did not substantiate abuse.  The facility Administrator and DON had previously investigated the incidents and did not substantiate abuse.  The Administrator reviewed injuries and grievance reports for July to determine if anything needed to be reported to OIG or APS.  Any future allegation of abuse will initially be reported to Adult Protective Services and the OIG office within 24 hours by Administrator, DON or designee.  The facility Administrator or DON will complete the investigation and forward results within 5 days.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

X NHA

X 8-2-11

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.

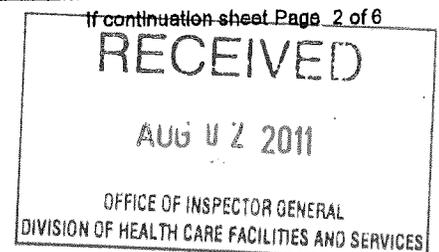
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F 226	Continued From page 1 non-patient care duties or suspended from duty until an investigation is completed. An incident can be determined to be "suspected abuse" and a report is made to the Adult Protection Agency and Licensure and Regulation Agency.  Review of the facility protocol regarding "Investigation", not dated, revealed it should include who was involved, resident's statements, involved staff and witness of event, description of resident's behavior and environment at time of incident. The reporting and response section of the protocol revealed the final report will include all relevant information regarding the incident and summary of action taken as a result of the investigation. This includes: 1. Measures utilized to safe guard the resident; 2. Termination of employee; 3. Disciplinary action of employee; 4. Counseling with the employee; 5. In-service or retraining employee; 6. Any other measure taken to resolve issues related to incident.  1. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 07/01/05 with diagnoses of Alzheimer Disease. Review of the plan of care revealed an alteration in cognitive ability and communication problems related to the Alzheimer Disease and the resident was depressed requiring the use of psychotropic medications. Review the admission Resident Assessment Instrument (RAI), dated 12/13/10, revealed the facility assessed the resident as extensive assist of two with bed mobility and transfers and displayed behaviors.  Review of the 07/18/11 facility investigation revealed an incident had been reported to the DON on 07/17/11 by LPN #1. A report had been	F 226	The investigation will include staff interviews, resident interviews when applicable and the facilities findings of whether the event is substantiated or not.  The facility will outline the areas taken as it relates to: 1) protecting the resident(s). 2) suspension/termination of employee. 3) Education of employee and/or staff.  The facility has scheduled an inservice on August 10, 2011 to review abuse/neglect. The inservice will include all staff in the nursing, housekeeping, administrative and dietary departments. This will be conducted by the Administrator and DON.  The Administrator will maintain an Allegation/Abuse log and a copy of the investigation. This will be reviewed monthly by the Administrator and no less than quarterly by the QA Committee.	



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F 226	<p>Continued From page 2</p> <p>made to LPN#1 that CNA #1 and CNA #2 were in Resident #1's room providing incontinent care. CNA #2 reported the resident pinched CNA #1, at which time CNA #1 pulled the resident's hand off and stated "Don't you pinch me". Further review of the investigation revealed an interview with CNA #1 indicated while CNA #2 was behind the resident performing incontinent care the resident pinched her and she removed the resident's hand and stated "Please do not pinch me". CNA #1 was suspended pending results of the investigation.</p> <p>Observation of Resident #1, on 07/21/11 at 12:30 PM, revealed the resident sitting in a geri-chair with bolsters on both sides of the chair to prevent injury. The resident was noted with multiple scratches and small bruising on the arms. A right wrist dressing revealed a small skin tear which was covered for protection. The resident was not interviewable.</p> <p>Interview with LPN #1, on 07/21/11 at 10:00 AM, revealed LPN #2 reported to her that CNA #2 had reported CNA #1 grabbed Resident #1's arm after the resident pinched her. LPN #1 stated an investigation was started and was treated as an alleged abuse situation. The DON was notified, suspended CNA #1 and completed a report. The nurse on duty made the determination, and if there was any question, would report it to the next level. The LPN revealed there was no injury or evidence that abuse had occurred in her investigation.</p> <p>Interview with CNA #1, on 07/22/11 at 11:00 AM, revealed during rounds with CNA #2 on 07/17/11 around 2:20 AM, Resident #1 became agitated</p>	F 226		

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F 226	Continued From page 3 and combative during care. Resident #1 began cursing and grabbed her arm and pinched it, and was trying to hit CNA #2. CNA #1 tried to hold the resident's arm to keep the resident from hitting CNA #2. CNA #1 stated she told Resident #1, "Please don't pinch me". CNA #1 stated they left the room and the facility suspended her around 3:45 AM.  However, interview with the DON, on 07/21/11 at 10:20 AM, revealed she did not report the alleged allegation of abuse incident to the state agencies, because she had determined it was not abuse. The DON revealed CNA #1 was removed until the investigation was completed. The DON stated Resident #1 was on blood thinning medication and bruises easily, is constantly pinching and scratching his/her own skin, which causes continuous abrasion areas on both arms. Both the Administrator and DON complete the investigation, however, only one person writes it up; all identified staff would be interviewed and the investigation was completed as a team. The DON would not have reported this incident, since they determined it was not abuse; the DON revealed she had consulted with the Administrator, who was out of town at the time. As of 07/21/11, the investigation had not been completed by the DON.  Interview with the Administrator per telephone, on 07/21/11 at 3:55 PM, revealed the determination was made by looking at skin assessments for Resident #1, and noting the resident had skin tears, frequent scratching, was on blood thinners, and had a nurse's entry on 07/18/11 referring to the multiple small bruises on the arms. The Administrator stated when a CNA says "please	F 226		

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F 226	<p>Continued From page 4</p> <p>don't pinch me", that would not be considered abuse.</p> <p>2. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 07/01/05 with diagnoses of Congestive Heart Failure, Peripheral Vascular Disease and Cerebral Vascular Accident. Review of the 06/08/11 behavior care plan revealed episodes of inappropriate behaviors and mood, and the resident continued to yell out.</p> <p>Observations of Resident #2 on tour, on 07/21/11 at 10:05 AM, revealed the resident lying in bed with no bruises or abrasions noted. Interview with the resident at 10:05 AM revealed no evidence that staff had been disrespectful; however, review of the quarterly MDS (minimum data set) assessment dated 03/10/11 revealed a BIMS score of 3 which assessed the resident as non-interviewable.</p> <p>Review of the 04/01/11 investigation revealed CNA #1 had put her hand over a resident when he/she was talking. There was no evidence included as to when the incident occurred, nor was the resident identified. The investigation also included three interviews with CNA #1, CNA #3 and LPN #1. Interview with CNA #3 revealed she was in the room with CNA #1, and stated she put her hand up when Resident #2 began to start yelling. CNA #3 also revealed CNA #1 at no time touched the resident. LPN #1 reported to the DON that CNA #1 put her hand in front of the resident's mouth when he/she was yelling, but at no time was he/she ever touched. CNA #1 did not remember putting the resident to bed that night.</p>	F 226		

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F 226	<p>Continued From page 5</p> <p>However, interview with CNA #1, on 07/22/11 at 11:00 AM, revealed the incident occurred several months ago when she and CNA #3 were standing beside Resident #2. CNA #1 stated the resident began to yell loudly, and was going to wake up other residents. The CNA stated she may have put two fingers up to her own mouth to try and stop the yelling. She never put her hand over the resident's mouth.</p> <p>Interview with LPN #1, on 07/21/11 at 10:00 PM, determined that CNA #1 did not put her hand over Resident #2's mouth; however, she did not report the allegation to the DON because her investigation showed no abuse.</p> <p>Interview with the Administrator, on 07/21/11 at 3:55 PM per telephone, revealed CAN #3 was the only witness and reported the incident to LPN #1. The Administrator stated the resident yells frequently and sometimes curses. The determination was based on what CNA #3 reported and witnessed, which showed there was no abuse. However, there was no evidence the incident was reported to the Administrator until a couple of months later when another allegation (Resident #1) had been reported. CNA #3 was unable to be interviewed and did not return call made on 07/21/11.</p> <p>Further interview with the Administrator, on 07/2011, revealed this was an allegation of abuse should have been reported.</p>	F 226		

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consistent with hitting hand on dining room table. Finger lined up with table.  
resident stated he bumped it going outside  
aide stated she bumped arm going to shower  
resident combative with care  
resident stated she bumped arm  
resident sleeps curled up and bumped them on footboard  
another resident accidentally ran over toes while out in lounge  
taking sleeve protector off and scratched resident  
staff observed resident picking at skin causing skin tear/bruise  
skin tear while washing residents feet  
resident combative with care  
resident stated she bumped legs while bedside table over bed.  
hoyer pad  
resident combative with care

No grievance reports

