

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

PRINTED: 11/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |                              |   |
|---|---|--|---|------------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185180 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                              | (X3) DATE SURVEY COMPLETED<br><br>C<br>11/02/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>NORTH HARDIN HEALTH & REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>599 ROGERSVILLE RD.<br>RADCLIFF, KY 40160  |                              |   |
| (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  | F 000  |   |                              |   |
| F 323<br>SS=E   | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review, it was determined the facility failed to ensure supervision and the safety of two (2) of three (3) sampled and two (2) unsampled residents. Resident #4 was observed to self-propel in a wheelchair throughout the facility with closed eyes, and was observed to bump into another resident, hitting the resident in the back of the wheelchair. Resident #5 was observed to enter the East Nurse's Station, while unsupervised and unwitnessed by staff, and handled items in the garbage can, then removed garbage bags from the trashcan and stored them in a pants pocket.</p> <p>The findings include:</p> | F 323  | <p>F-323</p> <p>1. The plan of care for resident # 4 was discussed by the interdisciplinary team on 11/05/2012. Resident #4 has been added to a restorative program to maintain her mobility and placed in a non-movable chair to ensure her safety and that of those residents around her.</p> <p>The plan of care for Resident #5 was discussed by the interdisciplinary team on 11/02/2012. The resident's hoarding behavior was discussed and a plan to utilize activities and a "store" was developed to allow resident to rummage through items in a protected environment.</p> <p>2. Unit Managers, ADON and DON reviewed 24 hour reports for the past 30 days, reports of incidents over the last 30days and behavior reports for the past 30days to identify any other residents at risk due to safety issues, such as accidents involving wheelchairs, wandering into other resident rooms, resident to resident altercations, hoarding, residents taking items from nurses stations or other public areas, ect. This will be completed by 12/5/2012.</p> | Completion by:<br>12/16/2012 |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE           |   | TITLE  |   | (X6) DATE                    |   |
| <i>X</i> <i>Ronald Johnson</i>  |   | <i>X</i> ADMINISTRATOR   |   | <i>X</i> 11-30-12            |   |

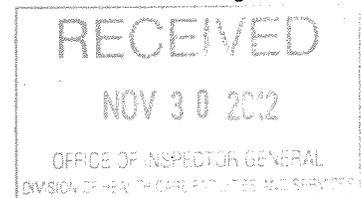
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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.

NOV 30 2012  
If continuation sheet Page 1 of 6  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES SERVICES

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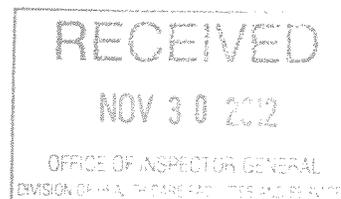
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| F 323   | Continued From page 1<br><br>1. Review of the clinical record for Resident #4 revealed diagnoses of Mental Disorder, Organic Brain Syndrome, Malaise and Fatigue, and a documented need for Rehabilitation Services. Review of the Care Plan for Resident #4 detailed an identified focus on Altered Mood with episodes of anxiety and crying, and a focus on short and long-term memory loss with impaired decision making abilities. Review of the Care Plan Conference, dated 08/28/12, documented Resident #4 self-propelled in a wheelchair daily around the nursing unit.<br><br>Observation, on 11/01/12 at 11:45 PM, revealed Resident #4 self-propelled around the East Nursing Station with closed eyes and bumped another resident in the back, who was sitting in a wheelchair near the nursing station. The resident who was bumped in the back stated Resident #4 intentionally hit him/her in the back and the resident cursed at Resident #4 before a staff member could intervene to separate the residents.<br><br>Interview, on 11/02/12 at 1:30 PM, with Masters of Science in Social Work (MSSW) #2 revealed Resident #4 did not have any sense of direction and stated staff attempt to redirect the resident when possible. MSSW #2 stated she saw Resident #4 roll into walls on multiple occasions.<br><br>Interview, on 11/02/12 at 3:58 PM, with LPN #1 revealed that she had observed Resident #4 to rock back and forward in the wheelchair, and said if another resident or staff member was in the way, Resident #4 would not stop. LPN #1 stated Resident #4 ran into walls and other residents in | F 323  | 3. Staff Development Director to provide education to all staff on Resident Behavior Management, with emphasis on identifying resident behaviors that put residents at risk, reporting behaviors, and on behavior management interventions. The initial education will be completed by 12/15/2012 and repeated monthly for 3 months then included as an annual in-service. All Newly hired employees will receive education on Resident Behavior Management during orientation. Interdisciplinary Team to review all care plans for residents identified as having behaviors that put themselves and others at risk, such as wandering into other residents rooms, self-mobile residents with lack of awareness of safety issues, residents with hoarding behaviors, ect to ensure care plans are appropriate to ensure the safety of the resident. This will be completed by 12/14/2012. Social Services (Kelly Bowman, Melody Tavera) to review all reports of incidents between residents, and all behavior reports weekly to identify behaviors that jeopardize the safety of any resident and will assume responsibility for the development of a care plan with the interdisciplinary team to address such behaviors. | Completion by:<br>12/16/2012. |   |



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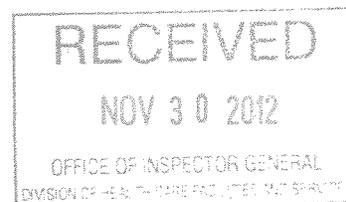
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| F 323   | Continued From page 2 wheelchairs.<br><br>Interview, on 11/02/12 at 5:11 PM, with LPN #2 revealed that she observed Resident #4 self-propel in a wheelchair through the facility with closed eyes, and considered this to be a risk to other resident's safety. LPN #2 stated she did not know how the facility could intervene to keep other residents from injury.<br><br>Interview, on 11/02/12 at 5:55 PM, with the Assistant Director of Nursing (ADON) revealed Resident #4 was a big challenge for the facility, and said when the resident was ambulatory, the resident would ambulate around the facility with closed eyes. The ADON stated the facility implemented the use of a wheelchair to assist Resident #4 with mobility in the facility. The ADON stated Resident #4 bumped into other objects and when staff observed the resident in a crowded area with other residents, staff would attempt to steer the resident into a more safe area. The ADON said she never encountered an incident when another resident was bumped or hurt by Resident #4 self-propelling in a wheelchair with eyes closed.<br><br>Interview, on 11/02/12 at 6:21 PM, with the Director of Nursing (DON) revealed she was aware Resident #4 self-propelled through both the East and West side of the facility with closed eyes. The DON stated that Resident #4 posed a risk of injury to another resident, but no more so than a resident with a walker or cane could pose a risk of injury to an ambulatory resident. The DON stated she had not witnessed Resident #4 to hit or bump into another resident or staff member. | F 323  | 4. Corporate Social Service Consultant to review no less than 10 residents with identified behaviors monthly for 3 months then quarterly to ensure appropriate care plans and interventions are in place for identified residents. ADON to review all reports of incidents, resident to resident altercations and any complaints from residents related to resident behaviors (wandering into room, taking personal belongings, ect) monthly for 3 months then quarterly to ensure care plans and interventions have been implemented to address such behaviors, and ensure the safety of all residents.<br><br>These reviews will be reviews by the facility QA Committee to ensure ongoing compliance. | Completion by:<br>12/16/2012 |   |



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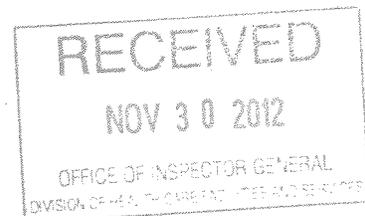
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| F 323  | Continued From page 3<br><br>2. Review of the clinical record for Resident #5 revealed the resident was admitted with diagnoses of: Transient Ischemic Attack/Stroke, Anxiety, and Mild Cognitive Impairment. Review of the Care Plan for Resident #5, revealed a focus identified for administration of a routine anti-depressant medication with an Intervention to monitor and document behaviors. Review of the Care Plan Conference for Resident #5, dated 10/03/12, revealed the resident was found on the floor on multiple occasions to 'keep from getting shot.'<br><br>Observation, on 11/02/12 at 10:00 AM, revealed Resident #5 was alone at the East Nurse's Station without staff supervision. Resident #5 self-propelled in a wheelchair, behind the Nurse's Station desk. Resident #5 examined the contents of the garbage cans with use of both hands, then removed empty trash bags from the garbage can and stored them in a pants pocket. Further observation, on 11/02/12 at 10:02 AM, revealed LPN #4 came to the Nurse's Station with a tray of food for resident #5 and assisted the resident into the sunroom for breakfast.<br><br>Interview, on 11/02/12 at 10:03 AM, with LPN #4 revealed she was not aware Resident #5 had been left unattended at the Nurse's Station. LPN #4 stated that Resident #5 had been observed by staff to take items from other residents and facility decorations and store the items in the resident's room. LPN #4 stated the trash bags presented a hazard to Resident #5 and staff should intervene to retrieve the bags from the resident.<br><br>Interview, on 11/02/12 at 1:30 PM, with MSSW #2 | F 323   |   |                      |   |



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| F 323  | <p>Continued From page 4</p> <p>revealed a family member returned other resident's items found in Resident #4's room to her. MSSW #2 stated that Resident #4 had been more confused recently since return from the hospital.</p> <p>Interview, on 11/02/12 at 10:45 AM, with the ADON revealed Resident #4 demonstrated hoarding of items the resident found in the facility, such as flowers and decorations. The ADON stated the trashbags Resident #4 took did not pose a hazard to the resident because the resident only intended to store them in his/her room.</p> <p>Interview, on 11/02/12 at 2:59 PM, with Certified Nursing Assistant (CNA) #1 revealed Resident #4 wandered in the facility in a wheelchair and was an elopement risk. CNA #1 stated Resident #4 was supposed to be visualized at all times, and said this was an intervention on the CNA Care Plan. CNA #1 said she had seen Resident #4 go into other resident rooms.</p> <p>Interview, on 11/02/12 at 6:21 PM, with the DON revealed she thought the trashbags taken by Resident #4 posed a potential hazard to the resident. The DON stated the resident's hoarding behaviors should be discussed at the Care Plan Meeting to identify appropriate interventions for hoarding behaviors.</p> <p>Interview, on 11/02/12 6:45 PM, with the Administrator revealed he was aware Resident #4 had been more confused and was taking items that did not belong to him/her. The Administrator stated Resident #4's behaviors had been discussed, but the facility had not attempted to</p> | F 323   |   |                      |   |



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| F 323   | Continued From page 5<br>address the demonstrated behaviors with a care plan.  | F 323  |   |                      |   |

