

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/21/2012
NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(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 #19064) was conducted on 09/20/12 through 09/21/12 to determine the facility's compliance with Federal requirements. KY #19064 was substantiated with deficiencies cited.	F 000	This plan of correction is submitted as the facility's credible allegation of compliance.	OCT 2 2012 RECEIVED INSPECTOR GENERAL	
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, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure staff implemented the written policies and procedure that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. On 09/02/12, between 5:00 PM and 5:30 PM, Certified Nurse Aide (CNA) #1 reported she heard 2-3 "slaps" as CNA #3 provided care to Resident #1. CNA #1 then reported this information to Licensed Practical Nurse (LPN) #1. Additionally, CNA #1 reported two other incidents of suspected abuse which involved CNA #3 toward Resident #1; however, she did not report the incidents at the time they occurred. Another CNA (#2) also reported overhearing CNA #3 make threatening comments to Resident #1, but did not report the incident to anyone. The staff failed to report suspected abuse to their supervisor immediately	F 226	F226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 1. The corrective action accomplished for those residents found to have been affected by the deficient practice. a. Resident #1 received a head to toe assessment by licensed staff on evening of 09/02/2012. b. Resident #1's skin was assessed 09/03/2012, 09/04/2012, & 09/05/2012. 2. The facility identified other residents having the potential to be affected by the same deficient practice. a. All residents residing in the facility had the potential to be affected by the same deficient practice. b. The weekly skin assessments were reviewed to determine if any changes were noted which could have been the result of this deficient practice. 3. The measures put in place to ensure that the deficient practice will not recur: a. Employees were in-serviced to the facility's policy/procedure and the mandate to follow the policy/procedure on abuse, neglect, mistreatment of residents and misappropriation of resident property.		

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

TITLE

(X6) DATE

Sandra J Dick

Administrator

10-12-12

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	<p>Continued From page 1 according to the facility's policy.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Resident Abuse," revised 02/11, revealed reporting suspected abuse/neglect is required by Kentucky Revised Statute 209. The employee identifying the abuse will immediately notify their supervisor. The supervisor will then notify the Social Worker on-call. In the event that the Social Services cannot immediately be reached, LTC Administrative Team member on-call will be notified. In addition, state social services shall be notified. Nothing in this section will relieve an employee of his/her obligation to report such findings in accordance KRS 209.</p> <p>A record review revealed the facility admitted Resident #1 on 03/05/10 with diagnoses to include Dementia, Hypertension, and Altered Mental Status. Further review revealed Resident #1 was transferred to a behavioral health facility on 09/07/12.</p> <p>An interview with CNA #1, on 09/20/12 at 2:50 PM, revealed she was in the room providing care to Resident #1's roommate when she overheard the "slaps." She revealed, at the time, she was unable to see anything because the privacy curtain was pulled between the two residents. After completing the resident's care, they (CNA #1 and CNA #2) reported this information to LPN #1. CNA #1 also reported she had previously observed CNA #3 "pop" Resident #1 on the hand and forehead. She thought the incident of CNA #3 "popping" Resident #1 on the hand was a reflex, so she did not report it to anyone. The</p>	F 226	<p>b. Employees were in-serviced on timely reporting.</p> <p>c. Employees were in-serviced on staff leaving area of residents when report is made which warrants implementation of facility policy.</p> <p>d. C.N.A. #1 and C.N.A. #2 were suspended without pay for not following the facility policy.</p> <p>e. C.N.A. #1 and C.N.A. #2 were informed any future failure to promptly report suspected abuse, neglect, mistreatment or misappropriation of resident property will result in termination of employment.</p> <p>f. L.P.N. #1 was in-serviced to facility policy/procedure.</p> <p>g. Social Workers will provide education to staff quarterly regarding signs and symptoms of abuse, neglect, mistreatment and misappropriation of resident property. Policy/procedure will be reviewed at in-service.</p> <p>4. The facility plan to monitor its performance to ensure that solutions are sustained by:</p> <p>a. D.O.N., A.D.O.N's, and R.N. Supervisors will review policy/procedure practices by all departments when reports are made.</p> <p>b. If facility fails to ensure compliance, then employees will receive suspension and termination of employment for repeated non-compliance.</p>	Completion Date 10/15/2012	

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F 226	<p>Continued From page 2</p> <p>incident regarding CNA #3 "popping" Resident #1 on the forehead should have been reported. There were no markings on the resident and she received a suspension related to not reporting suspected abuse immediately.</p> <p>An interview with CNA #2, on 09/20/12 at 2:33 PM, revealed she was in the room providing care to Resident #1's roommate, but she did not hear any "slapping" sound. She reported to LPN #1, on 09/02/12, about overhearing CNA #3 tell Resident #1 "if you do that again I'll hit you"; however, the incident did not happen on that day. She revealed she was not thinking clearly by not reporting what she overheard CNA #3 say to the resident. She was aware she should report suspected abuse at the time it was observed.</p> <p>An interview with CNA #3, on 09/20/12 at 3:15 PM, revealed she was providing care to Resident #1 when CNA #1 and CNA #2 came in to provide care to the roommate. Resident #1 bit her on the forearm during provision of incontinent care. CNA #3 stated she "tapped" him/her on the arm 3-4 times and asked the resident to let go. The resident looked at the CNA, then released her arm from his/her mouth. He/she continued to hit and "slap" at the staff until they completed the care and exited the room. CNA #3 denied threatening Resident #1 or hitting the resident on the hand. She revealed she put her hand on the resident's forehead to keep from hitting the mechanical lift while being hooked up to the arms of the lift. She revealed she was expected to report immediately to the supervisor if she saw or heard anything abusive.</p> <p>An interview with LPN #1, on 09/21/12 at 1:35</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>PM, revealed, on 09/02/12 between 6:30 PM and 6:00 PM, CNA #1 reported she observed CNA #3 "pop" Resident #1 on his/her head earlier in the day, and she had witnessed this before. LPN #1 directed CNA #1 to write a statement and then reported the alleged incident to Registered Nurse (RN) #1. RN #1 took over and she returned to the nursing station where she observed CNA #3 in the dining room feeding residents. She did not know the facility's protocol related to abuse. LPN #1 reported she did not know she had to remove the "accused" person from direct care, but she was aware of it now.</p> <p>An interview with RN #1, on 09/21/12 at 2:30 PM, revealed she was informed of an allegation of abuse by LPN #1 around 6:10 PM to 6:25 PM. She reported the aides came and told her they heard a "slap" while CNA #3 provided care to Resident #1. The CNA who reported the alleged abuse stated the curtain was pulled and she did not see anything. RN #1 revealed she assessed the resident and found no evidence of any markings on the resident. CNA #3 was removed from direct resident care. The RN attempted to contact the DON but she did not answer. RN #1 then called Social Services and the Administrator. She was directed by the Administrator to not allow any of the staff to leave and that the Administrator would come in to talk with them. The staff were expected to report suspected abuse immediately and remove the staff from direct resident care, and contact the Director of Nursing (DON) and Administrator.</p> <p>An interview with the DON, on 09/21/12 at 3:30 PM, revealed the staff responded appropriately with the incident that was identified on 09/02/12;</p>	F 226		

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F 226	Continued From page 4 however, the staff did not respond appropriately when they reported the previous incidents of suspected abuse. The staff were trained on abuse/neglect in orientation and throughout the year. She stated abuse allegations were to be reported immediately to the supervisor, then they were to notify the Administrator, who would then contact the DON. An interview with the Administrator, on 09/21/12 at 3:50 PM, revealed the staff were trained on abuse/neglect. The staff completed mandatory madness which was a computer program and they were tested over the content for written confirmation of the training. Social Services provided quarterly training on abuse/neglect. She stated the staff did not respond appropriately when they reported information about the other abusive situations.	F 226			