

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

PRINTED: 01/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

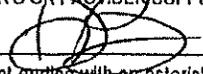
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| STATEMENT OF DEFICIENCIES<br>PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>185354 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>12/19/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FORDSVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>313 MAIN STREET<br>FORDSVILLE, KY 42343 |
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| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
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| F 000         | INITIAL COMMENTS  | F 000 |  |  |
| F 226<br>SS=D | <p>483.13(c) DEVELOP/IMPLMENT<br/>ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, record review and review of facility policy it was determined the facility failed to implement the facility's abuse/neglect policy and procedure related to an allegation of mistreatment. Resident #3 had reported to two Certified Nurse Aides (CNA) that Licensed Practical Nurse (LPN) #1 had rolled him/her out of his/her room when the resident was attempting to transfer him/herself to the bed side commode. The Administrator was not notified of the allegation timely and LPN #1 was not removed from the facility immediately.</p> <p>Findings include:<br/>Review of the undated facility policy titled, ABUSE AND NEGLECT POLICY, revealed the facility should prohibit abuse of residents from any source, to promote the well-being of</p> | F 226 |  |  |

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



TITLE

Administrator

(X6) DATE

1/11/2013

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</p> <p>residents by providing a safe and supportive environment and to maintain the resident's right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion. The policy also stated the facility administration will immediately suspend staff who are alleged to have or be suspicious for abuse and or neglect and notify the Office of Inspector General, Adult Protective Services, and local law enforcement authority.</p> <p>Record review revealed Resident #3 was admitted to the facility with diagnoses to include Diabetes Mellitus, Above the Knee Amputation and Diabetic Neuropathy. A review of the quarterly Minimum Data Set (MDS) assessment, dated 11/17/12, revealed the facility assessed Resident #3 with no cognitive impairment and the resident required extensive assistance of two staff for transfers with mechanical lift and was continent of bowel and bladder.</p> <p>Observation and interview, on 12/19/12 at 9:00 AM, revealed Resident #3 was in bed and dressed in a gown. The resident stated he/she asked for assistance on 12/09/12 to the bed side commode as he/she takes Lasix (fluid pill) in the morning and has to void frequently and urgently for a few hours. She stated staff was aware of that but no one came to assist him/her. Resident #3 stated LPN #1 had entered the room and rolled him/her backwards out of the room away from the bedside commode without helping him/her to use the commode. The resident stated he/she had no problems with LPN #1 prior to the incident, but he/she did not feel good about what had happened.</p> | F 226  | <p>This plan of correction is submitted per requirement by State but does not constitute admission or agreement by the provider of the alleged facts or conclusions set forth in this statement of deficiencies.</p> <p>F226</p> <ol style="list-style-type: none"> <li>1. The Administrator was notified of the incident related to resident # 3 on 12/10/12. The Licensed Practical Nurse #1 was suspended on 12/10/12. The Administrator re-educated the Assistant Director of Nursing on immediate notification of any allegation of abuse and neglect on 12/19/12.</li> <li>2. All alert and oriented residents were interviewed by Medical Records (Licensed Practical Nurse) on 12/11/12 to ensure that there were no further allegations of abuse or neglect. No other issues were noted.</li> <li>3. The Administrator will provide re-education to all staff on the facility Abuse and Neglect policy and immediate notification of any</li> </ol> | 2-1-2013  |

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| F 226 | Continued From page 2<br>An interview with LPN #1, conducted on 12/19/12 at 9:15 AM, revealed on 12/09/12 at 2:00 PM, two CNAs had told the LPN Resident #3 had complained that she (LPN #1) had taken away Resident #3's bed side commode. LPN #1 stated she had been walking to another resident's room with medication and had heard Resident #1 yelling. Resident #1 was saying he/she was going to transfer his/herself. LPN #1 continued on and administered a medication to another resident, then returned to Resident #3's room where she observed Resident #3 attempting to self transfer to the bed side commode. LPN #1 told Resident #3 she could not allow him/her to self transfer as he/she was a two person assist and Resident #3 began crying stating he/she hated this place. LPN #1 stated she attempted to contact the on call administrative staff to notify her of the allegation but did not get an answer. She also attempted to contact the Director of Nursing (DON) without success. LPN #1 was successful in contacting the Assistant Director of Nursing (ADON) at 2:30 PM and informed her of Resident #3's complaint. The ADON instructed LPN #1 to get written statements from the two CNAs but they had already left for the day. LPN #1 did not document anything about the event in the nursing notes because the ADON told her not to. LPN #1 stated she returned to work on Monday, 12/10/12 at 7:00 AM and asked the Administrator if she was suspended. The Administrator did not know anything about the event. LPN #1 revealed she worked until 11:45 AM at which time the Administrator notified her she was suspended pending an investigation and she clocked out and went home. She stated she was terminated by the facility on 12/13/12 for "inconsiderate care". | F 226 | 4. allegation by 1/31/13. Staff re-education on the Facility Abuse and Neglect Policy will be provided monthly for three (3) months by the Administrator or Director of Nursing. All alert and oriented residents will be interviewed by the Social Service Director weekly for twelve (12) weeks to ensure facility staff are adhering to the policy for allegations of abuse and neglect. The Administrator will review all resident concerns weekly for twelve (12) weeks to assure compliance with the facility policy for allegations of abuse and neglect. The results of the audits will be reviewed by the Quality Assurance Committee consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing, And the Life enrichment Director monthly for three (3) months. The Medial Director will attend at least quarterly. If at |  |
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| F 226  | <p>Continued From page 3</p> <p>An interview with CNA #1, conducted on 12/19/12 at 11:00 AM, revealed on 12/09/12 that Resident #3 had requested assistance to the bed side commode about 12:30 PM after lunch. CNA #1 told Resident #3 he/she would have to wait because she couldn't assist him/her without a second staff due to being a two person assist with transfers. CNA #1 went to get another CNA who was supervising other residents who were smoking. CNA #1 returned to Resident #3 after assisting another resident who had requested assistance before Resident #3. The CNA stated Resident #3 was upset due to having to wait and wanted to go home. Resident #3 did not say anything about LPN #1.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 12/19/12 at 11:45 AM, revealed she was not on call on 12/09/12 but did remember getting a call from LPN #1 and she told the LPN to obtain statements from the CNAs. The ADON stated LPN #1 should have been removed from care at that time.</p> <p>An with LPN #2, on 12/19/12 at 12:25 PM, revealed on 12/09/12 that Resident #3 had come to the nursing station and his/her face was red and he/she was crying. The resident explained to LPN #2 that he/she had taken a fluid pill and the CNAs were putting him/her off. Resident #3 told LPN #2 that LPN #1 had jerked his/her chair back when he/she had said he/she was going to transfer him/herself. LPN #2 went to LPN #1 and told her what had been said and they went to the nursing station to call whoever was on call. LPN #2 stated LPN #1 contacted someone but she did not know who but whoever it was told LPN #1 to</p> | F 226  | any time concerns are identified, the Quality Assurance Committee will meet to analyze and implement further measures dependent upon the root cause to assure ongoing compliance. |                      |   |

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| F 226  | Continued From page 4<br>get statements. LPN #1 called the CNAs at home to get statements. LPN #1 finished her shift and did not leave the building until the end of the shift.<br><br>An interview with the DON, on 12/19/12 at 12:10 PM, revealed she had been off during the time of the allegation. The DON stated it was her understanding after talking to staff about the incident that Resident #3 was going to transfer him/herself and LPN #1 had pulled him/her back away from the bedside commode. Resident #3 complained of neck pain and an x-ray was obtained that was negative for any injury. The DON stated she thought LPN #1 was trying to prevent a fall and the ADON wasn't thinking abuse/neglect. The DON also stated she did not know why LPN #1 did not just get someone from another hall to assist the resident to the bedside commode.<br><br>An interview with the Administrator, on 12/19/12 at 11:30 AM, revealed statements had been obtained related to the incident with Resident #3. There was no documented incident report. The Administrator stated he felt Resident #3 had waited too long to go to the toilet and that LPN #1 already had behavioral issues and he terminated LPN #1 on 12/13/12 for inconsiderate care. The Administrator also stated staff usually notified him of such issues. He said he was not notified of the issue with Resident #3 on 12/09/12 and should have been. He stated staff was to make any situation safe and if an employee was involved the employee was to be removed. | F 226  |   |                      |   |
| F 323<br>SS=D  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  | F 323  |   |                      |   |

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| F 323  | <p>Continued From page 5</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 interviews, observations, record reviews, and policy review, it was determined the facility failed to ensure residents received adequate supervision and functioning assistance devices to prevent accidents for one resident (#1), in the selected sample of three. The facility failed to ensure Resident #1's safety bed alarm was in the functioning mode. Multiple observations revealed the safety alarm in place, however, the indicator light indicated it was not in the functioning mode.</p> <p>The findings include:</p> <p>Review of manufacturer's instructions, revealed, "In-use light notifies you at a glance that the unit is properly operating. The in-use light will blink every 3 seconds to indicate that pressure has been applied to the pad. Monitor will alarm/alert when pressure is removed from the pad."</p> <p>Record review revealed Resident #1 was admitted to the facility on 07/01/12 with diagnoses to include Senile Dementia, Osteoarthritis, Benign Hypertension, Eating Disorder, Convulsions, Hypothyroidism, Psychosis, and</p> | F 323  | <p>F323</p> <ol style="list-style-type: none"> <li>1. The sensor bed alarm for Resident 1 was replaced on 12/18/12 and functioning as verified by the Director of Nursing.</li> <li>2. All sensor bed alarms were audited by the Assistant Director of Nursing on 12/19/12 to ensure proper functioning, with no other issues noted.</li> <li>3. All licensed staff will be re-educated by the Director of Nursing or Assistant Director of Nursing by 1/31/13 on proper procedure for verifying functioning of sensor alarms per manufacturer's guidelines.</li> <li>4. The Director of Nursing or Assistant Director of Nursing will perform Alarm checks three (3) times a week for three (3)</li> </ol> | 2-1-2013             |   |

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| F 323  | <p>Continued From page 6</p> <p>Esophageal Reflux. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/01/12, revealed the facility assessed Resident #1 with severe cognitive impairment, unable to make needs known, non-ambulatory, and required total care and lift transfer with two assist. A review of the Comprehensive Care Plan, dated 12/17/12, and December 2012 Treatment Administration Record (TAR) revealed the use of a bed alarm with placement and function of the alarm being tested every shift.</p> <p>Observation on 12/18/12 at 12:00 PM revealed Resident #1's bed alarm was not functioning properly as evidenced by the lack of the indicator light not flashing on the alarm. Certified Nurse Aide (CNA) #3 was observed to unplug the alarm cord from the alarm box and then plug the alarm cord back into the box without the alarm sounding. CNA #3 then tapped on the alarm pad under the resident on the bed several times before it sounded.</p> <p>Observation on 12/18/12 at 12:10 PM revealed that the indicator light on the bed alarm to Resident #1's bed was not flashing, indicating it was not functioning properly. Interview with CNA #3 concerning the bed alarm light and lack of sound emitting from the alarm when triggered revealed "It may have a short or something, we change it when we have a problem with it; we tell the nurse but we change it." CNA #3 notified the Administrator.</p> <p>Interview with CNA #3, on 12/18/12 at 12:12 PM, revealed that the bed alarm had not been changed. She stated RN #3 checked the alarm and said it was working OK and we'll see how it is</p> | F 323  | <p>months to ensure sensor bed alarms are functioning per Manufacturer's guidelines. The results will be reviewed by the Quality Assurance Committee consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the Life enrichment Director monthly for three (3) months. The Medical Director will attend at least Quarterly. If at any time concerns are identified, the Quality Assurance Committee will meet to analyze and implement further measures dependent upon the root cause to assure ongoing compliance</p> |                      |   |

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| F 323  | <p>Continued From page 7<br/>working when we change him/her.</p> <p>Interview with Registered Nurse (RN) #3, on 12/18/12 at 12:15 PM, revealed she tested the bed alarm sensor and it seemed OK, so it was not replaced.</p> <p>Observation on 12/18/12 at 12:25 PM and at 2:00 PM, revealed that the bed alarm indicator light on Resident #1's bed alarm was not flashing.</p> <p>Observation of CNA #1 on 12/18/12 at 2:06 PM, revealed CNA #1 looked at the alarm and touched the bed pad alarm but no sound was emitted from the bed alarm when touched.</p> <p>Observation on 12/18/12 at 2:45 PM till 2:50 PM, revealed the bed alarm light on Resident #1's bed only flashed one time in five minutes.</p> <p>Observation of Resident #1 during incontinent care, on 12/18/12 at 3:30 PM, revealed the alarm did not sound while incontinent care was being provided and the resident was being rolled from side to side. The bed alarm did not sound when CNA #6 unplugged the alarm cord then plugged it back in. CNA #6 revealed the light on the bed alarm of Resident #1 was not flashing at this time and that the bed alarm cord was still attached to the bed pad.</p> <p>Review of the Alarm Audit, dated 12/18/12, revealed that 6 AM-2 PM and 2 PM-10 PM shifts signed indicating Resident #1's alarm was functioning properly.</p> <p>Interview with Director of Nursing (DON), on 12/18/12 at 4:00 PM, revealed that bed alarms</p> | F 323  |   |                      |   |

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| F 323  | Continued From page 8<br>were checked by the CNAs to see if functioning by setting it off and verified checked by the Initialing on the Alarm Audit. | F 323  |   |                      |   |