

(M C B R A Y E R)

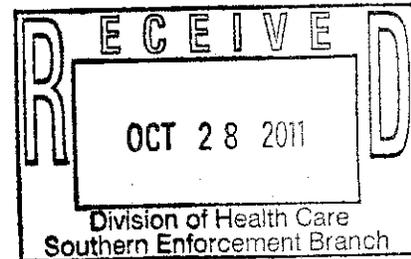
McBrayer, McGinnis, Leslie & Kirkland, PLLC

ATTORNEYS AT LAW

201 EAST MAIN STREET, SUITE 1000
LEXINGTON, KENTUCKY 40507
(859) 231-8780 EXT. 256
FAX: (859) 281-6480

October 28, 2011

Cabinet for Health and Family Services
Office of Inspector General
Division of Health Care
116 Commerce Avenue
London, Kentucky 40477



RE: Supplement to Addendum to Second Plan of Correction
Facility Name: Charleston Health Care Center
Facility Address: 203 Bruce Court, PO Box 426, Danville, Kentucky 40423
Administrator:
Provider Number: 185264

Dear Ms. Goins:

I am writing on behalf of our firm's client Charleston Health Care Center to supplement its Addendum to the Plan of Correction dated October 20, 2011. Please accept the Supplement as follows:

- **F-223**

To address the concerns of the Office of Inspector General, the Facility has supplemented its Plan of Correction and Addendum. The Facility achieved substantial compliance as of 9/20/11. Even though Charleston has taken additional steps that included reorganization and restatement of its abuse policies and procedures (10/12/11) as well as additional education of staff about abuse policies (10/13/11), these steps were not necessary for compliance and reflect only Charleston's ongoing commitment to compliance.

- **F-225**

To address the concerns of the Office of Inspector General, the Facility has supplemented its Plan of Correction and Addendum. The Facility achieved substantial

compliance as of 9/20/11. Even though Charleston has taken additional steps that included reorganization and restatement of its abuse policies and procedures (10/12/11) as well as additional education of staff about abuse policies (10/13/11), these steps were not necessary for compliance and reflect only Charleston's ongoing commitment to compliance.

- **F-226**

To address the concerns of the Office of Inspector General, the Facility has supplemented its Plan of Correction and Addendum. The Facility achieved substantial compliance as of 9/20/11. Even though Charleston has taken additional steps that included reorganization and restatement of its abuse policies and procedures (10/12/11) as well as additional education of staff about abuse policies (10/13/11), these steps were not necessary for compliance and reflect only Charleston's ongoing commitment to compliance.

- **F-323**

To address the concerns of the Office of Inspector General, the Facility has supplemented its Plan of Correction and Addendum. The Facility achieved substantial compliance as of 9/20/11. Even though Charleston has taken additional steps that included reorganization and restatement of its abuse policies and procedures (10/12/11) as well as additional education of staff about abuse policies (10/13/11), these steps were not necessary for compliance and reflect only Charleston's ongoing commitment to compliance.

- **F-490**

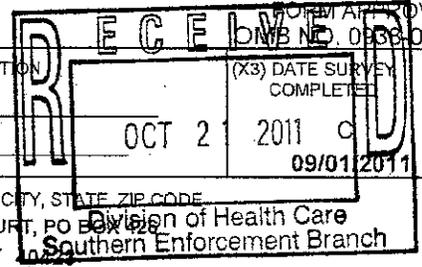
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 10/12/2011

FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED OCT 2 2011 09/01/2011
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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 128 DANVILLE, KY 40419 Division of Health Care Southern Enforcement Branch
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(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	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey was initiated on 08/22/11, and a standard health/extended survey was conducted on 08/29/11-09/01/11. The survey began with the investigation of KY16909 on 08/22/11. KY16591 and KY16696 were initiated on 08/24/11. KY16696 was unsubstantiated with no related deficient practice. KY16591 and KY16909 were substantiated with deficient practice identified.</p> <p>Immediate Jeopardy was identified on 08/25/11, and determined to exist on 07/19/11. The facility was notified on 08/25/11. Interview and record review revealed three allegations of physical and verbal abuse involving State Registered Nurse Aide (SRNA) #8 were reported to the facility's administrative staff on 07/19/11, 07/21/11, and 08/10/11. The facility failed to protect residents after each allegation of abuse was reported, failed to complete a thorough investigation, and failed to report the allegations of abuse to the appropriate state agencies.</p> <p>Deficiencies were cited at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490) at a scope and severity of "K." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226).</p> <p>An acceptable Allegation of Compliance was received on 08/31/11, which alleged removal of Immediate Jeopardy on 08/31/11. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" at 42 CFR 483.13</p>	F 000	<p>See attached Addendum to the Plan of Correction for:</p> <p>F 223 F 225 F 226 F 253 F 282 F 314 F 323 F 371 F 441 F 490</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Pus	(X6) DATE 10-20-11
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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 000	Continued From page 1 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000		
F 223 SS=K	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigations and policies, it was determined the facility failed to have an effective system in place to ensure two (2) of twenty-two (22) sampled residents (Residents #1 and #2) were free from verbal, sexual, physical, and mental abuse. The facility failed to ensure allegations of abuse were immediately reported to administrative staff, failed to ensure residents were protected from abuse and allowed an alleged perpetrator to continue to work during the facility's investigation, failed to conduct a thorough investigation in order to reach a conclusion that an allegation of abuse was substantiated/unsubstantiated, and failed to report all allegations of abuse to the appropriate state agencies.	F 223		

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F 223	<p>Continued From page 2</p> <p>On 07/19/11, Certified Medication Aide (CMA) #1 witnessed State Registered Nurse Aide (SRNA) #8 being physically and verbally rough with Resident #2 and reported the incident to the Director of Nursing (DON). However, SRNA #8 was not suspended, an investigation was not conducted, and the appropriate state agencies were not notified.</p> <p>On 07/21/11, Resident #2 reported SRNA #8 physically abused the resident on the evening of 07/20/11. The resident's allegation was reported to the DON and statements were obtained from staff. However, the facility failed to conduct a thorough investigation and the appropriate state agencies were not notified of the allegation. The facility also failed to protect Resident #2 during the investigation and allowed SRNA #8 to continue to work for three days following the resident's report of the allegation. The SRNA was suspended for two days (07/25-26/11).</p> <p>On 08/10/11, SRNA #2 witnessed SRNA #8 "jump" onto the bed with Resident #1 and to "spoon" and kiss the resident. SRNA #2 reported the allegation to her supervisor but the supervisor failed to report the allegation. The allegation was overheard by Resident #3 and this resident informed SRNA #9. SRNA #9 reported the allegation to Licensed Practical Nurse (LPN) #6 on 08/11/11 at approximately 6:45 AM; however, LPN #6 waited 26 hours before informing the Human Resources Director (HRD) on 08/12/11 at 8:30 AM, about the allegation. The Assistant Administrator was informed of the allegation at approximately 10:30 AM on 08/12/11, and SRNA #8 was removed from the facility, terminated, and escorted off the premises by Law Enforcement.</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>The Assistant Administrator confirmed the appropriate state agencies had not been notified of the allegation and a thorough investigation had not been conducted.</p> <p>During the state agency's investigation, interviews revealed SRNA #8 had a history of inappropriate behaviors towards residents; however, there was no evidence the facility investigated or reported these behaviors to the appropriate state agencies.</p> <p>The facility's failure to ensure staff immediately reported all allegations of abuse to administrative staff, failure to protect residents from abuse during the facility's investigation, failure to conduct a thorough investigation, and failure to report all allegations of abuse to the appropriate state agencies, has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and Resident #2 and other residents in the facility. Immediate Jeopardy and Substandard Quality of Care (SQC) were determined to exist on 07/19/11.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/31/11, and alleged removal of Immediate Jeopardy on 08/31/11. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Abuse Policy (revised 09/06/00) revealed, "In the event of any evidence</p>	F 223		
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F 223	Continued From page 4 to cause to believe that a resident has suffered any abuse, the employee, visitor or family member are requested to report any/all allegations; suspicion, or incidents to the administration of the facility, i.e. charge nurses, supervisors, DON, SSD, or administrator." The policy stated, "Upon report of any allegations or violations, the administration will thoroughly investigate the situation. Any employee suspected of abuse, neglect, or disregard for resident welfare will be suspended from direct resident care while the investigation is in progress." The review revealed the investigation would include, but not be limited, to the following: names of all individuals involved, witnesses that actually viewed the incident, the resident's/family's statement concerning the incident, when and where the incident occurred and any evidence of injury or abuse present on the resident's body or in the resident's actions. The policy revealed, "The results of the investigation shall be documented and placed in the investigation file." The policy also revealed, "After knowledge of an allegation of abuse, the administrator, director of nursing or social service director shall report it to Adult Protective Services and the Cabinet for Human Resources immediately. The results of all investigations will be reported to the same agencies within five (5) working days of the incident." 1. An interview conducted on 08/22/11 at 2:45 PM, with Certified Medication Aide (CMA) #1 revealed on 07/19/11, she witnessed SRNA #8 being physically, mentally, and verbally abusive to Resident #2 and Resident #8. The CMA reported SRNA #8's behavior to the DON the next morning on 07/20/11. Interview on 08/24/11 at 7:05 PM,	F 223		

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F 223	<p>Continued From page 5</p> <p>with the DON revealed she did not recall CMA #1's allegation against SRNA #8. Therefore, SRNA #8 was not suspended, no investigation was conducted, and the appropriate state agencies were not notified.</p> <p>An interview conducted on 08/22/11 at 5:20 PM, with State Registered Nurse Aide (SRNA) #1, revealed SRNA #8 had a history of being rude and threatened/intimidated Resident #2 by saying to the resident, "You apologize or else," "No, you're not getting up," and would refuse to transfer the resident to the chair. According to SRNA #1, she could not remember when she witnessed this incident but she did report SRNA #8's behaviors to the Human Resources Director (HRD). Interview on 08/24/11 at 6:35 PM, with the HRD revealed she did not recall SRNA #1's allegation against SRNA #8. Therefore, SRNA #8 was not suspended, no investigation was conducted, and the appropriate state agencies were not notified.</p> <p>Interviews conducted on 08/22/11 at 7:00 PM, with the Assistant Administrator, and on 08/25/11 at 6:05 PM, with the Administrator revealed they were unaware of the above allegations against SRNA #8.</p> <p>2. A review of the facility's investigation of Resident #2's allegation, undated, revealed the facility had obtained statements from eight employees, the DON, and the alleged perpetrator. The DON's statement dated 07/21/11, revealed staff reported Resident #2 said SRNA #8 "beat" the resident up during the 3-11 PM shift on 07/20/11. The statement revealed the Administrator was notified of the</p>	F 223		

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F 223	<p>Continued From page 6</p> <p>allegation at approximately 8:20 AM on 07/21/11; and stated, "Not to report as this didn't happen." The review revealed Resident #2 came to the DON at approximately 10:55 AM on 07/21/11, and asked, "What are you going to do about" SRNA #8 and the resident proceeded to inform the DON that SRNA #8 "put a pillow over my face and then hit me on each side of my head." The statement revealed at 12:10 PM on 07/21/11, the DON reported the allegation again to the Administrator who stated, "Quit worrying about this;" the resident is "crazy." The review revealed SRNA #8 was suspended on 07/25/11 at 3:00 PM, four days after the allegation was made. There was no evidence a thorough investigation had been completed or that the appropriate state agencies had been notified of the allegation.</p> <p>A review of Resident #2's medical record revealed the facility admitted the resident on 09/14/10, with diagnoses of Schizophrenia, Closed Head Injury, Depression, Multiple CVAs, Hypertension, Seizures, and Left sided weakness. A review of Resident #2's Quarterly MDS assessment dated 06/15/11, revealed the resident's cognition was intact and the resident required extensive assistance of two staff persons with bed mobility, transfers, dressing, and toileting.</p> <p>An interview conducted on 08/22/11 at 6:15 PM, with Resident #2 revealed SRNA #8 was not good to him/her. Resident #2 stated, "He tried to kill me," by placing a pillow over the resident's face and "tried to smother me." According to the resident, SRNA #8 "hit me four times," two times on each side of the resident's head.</p>	F 223		

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F 223	<p>Continued From page 7</p> <p>An interview conducted on 08/22/11 at 2:11 PM, with the Minimum Data Set (MDS) Coordinator revealed she assisted Resident #2 on the morning of 07/21/11, and at that time the resident reported SRNA #8 had hit the resident on the head. The interview revealed the MDS Coordinator reported Resident #2's allegation to the DON.</p> <p>Interviews conducted on 08/22/11 at 3:30 PM, with Registered Nurse (RN) #1 and on 08/22/11 at 2:45 PM, with Certified Medication Aide (CMA) #1 revealed on 07/21/11, Resident #2 reported SRNA #8 put a pillow over the resident's face and hit the resident on the head four times. RN #1 stated Resident #2 was "very convincing" and the allegation was reported to the DON. CMA #1 stated at the time of the allegation she noted a small bruise to the left side of the resident's face on the cheek area that was not present the previous day. The CMA reported Resident #2's allegation to the MDS Coordinator and wrote a statement.</p> <p>An interview conducted on 08/22/11 at 6:30 PM, and on 08/24/11 at 7:05 PM, with the DON revealed on the morning of 07/21/11, staff reported to her that Resident #2 alleged SRNA #8 had physically beat the resident. The DON informed the Administrator and was instructed not to report the allegation. The interview revealed later that same day Resident #2 came to the DON and asked what she was going to do about SRNA #8 putting a pillow over the resident's face and beating the resident up. The DON again informed the Administrator of the allegation and was instructed to "stop worrying," that Resident #2 was "crazy." According to the DON, staff</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>statements were obtained; however, SRNA #8 continued to work on 07/22/11, 07/23/11, and 07/24/11, until the Assistant Administrator returned from vacation and was informed of the allegation. The interview revealed SRNA #8 was suspended on 07/25/11 and 07/26/11, and was assigned to a different unit and shift when he returned to work. The DON stated an investigation had been conducted with no conclusion reached and stated the Assistant Administrator notified the Department for Community Based Services (DCBS) on 07/25/11. However, based on interview, the facility failed to ensure all appropriate agencies had been notified of the allegations. The DON denied that staff had reported SRNA #8 had been rough with any of the residents prior to this allegation.</p> <p>An interview conducted on 08/22/11 at 7:00 PM, with the Assistant Administrator, confirmed SRNA #8 worked on 07/22-24/11, and was suspended on 07/25/11, until the investigation was completed. The Assistant Administrator stated the SRNA was allowed to return to work on 07/27/11, on a different shift and unit. The Assistant Administrator stated due to Resident #2's history of head injury and that the resident recanted the allegation the facility felt the allegation was not true and did not report the allegation to the appropriate state agencies.</p> <p>An interview conducted on 08/25/11 at 6:05 PM, with the Administrator revealed the Administrator was informed of Resident #2's allegation on 07/21/11, and due to the resident's "delusional" status the allegation was not reported to the appropriate state agencies.</p>	F 223		

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F 223	<p>Continued From page 9</p> <p>3. A review of the facility's undated investigation of the allegation that SRNA #8 laid on the bed with Resident #1 and spooned with the resident revealed statements were obtained from 12 staff members and the Assistant Administrator. There was no documentation of a conclusion, summary of investigative findings, or that all appropriate state agencies had been notified of the allegation.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 11/06/09, with diagnoses of Lumbar Compression Fractures, Falls, Weakness, Right Subdural Hematoma, Cardiomegaly, Deaf, Congestive Heart Failure, and Depression. A review of Resident #1's comprehensive Annual Minimum Data Set (MDS) assessment dated 11/13/10 revealed the resident's cognition was severely impaired and the resident was independent with no setup needed for transfers, dressing, toileting, and hygiene.</p> <p>An interview conducted on 08/23/11 at 10:10 AM, with SRNA #2 revealed on 08/10/11, during the 7 AM-3 PM shift, she witnessed SRNA #8 come into Resident #1's room, jump on the bed, lie down on the bed, and "spoon" the resident. SRNA #8 proceeded to kiss Resident #1, got off the bed, and left the room. SRNA #2 ensured Resident #1 was all right and completed her duties and then reported the allegation to her supervisor (Restorative Aide #2). An interview conducted on 08/25/11 at 8:10 AM, with Restorative Aide (RA) #2 confirmed SRNA #2 reported the allegation but staff failed to report the allegation to administrative staff.</p> <p>An interview conducted on 08/22/11 at 3:11 PM,</p>	F 223		

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F 223	<p>Continued From page 10</p> <p>with SRNA #7 revealed SRNA #2 informed SRNA #7, in the presence of Resident #3, that she (SRNA #2) witnessed SRNA #8 get in bed with a female resident and lie with his body against the resident's body.</p> <p>An interview conducted on 08/29/11 at 4:30 PM, with SRNA #9 revealed in the early morning on 08/11/11, Resident #3 informed her that another SRNA found SRNA #8 on top of a 90-year-old female resident. The interview revealed SRNA #9 immediately reported the allegation to LPN #6.</p> <p>An interview conducted on 08/24/11 at 5:15 PM, with LPN #6 confirmed she was informed at approximately 6:45 AM on 08/11/11, by SRNA #9, that Resident #3 reported SRNA #8 was found in bed with a female resident. The LPN waited 26 hours after being informed of the allegation to report the allegation to the HRD on 08/12/11.</p> <p>Interviews conducted on 08/22/11 at 4:45 PM, with the HRD, and on 08/22/11 at 2:11 PM, with the MDS Coordinator revealed on 08/12/11 at approximately 8:30 AM, LPN #6 stated that Resident #3 reported that an aide found a male SRNA on top of a female resident. The Assistant Administrator was notified of the allegation on 08/12/11 at approximately 10:30 AM, by the HRD and MDS Coordinator.</p> <p>An interview conducted on 08/22/11 at 7:00 PM, and 08/24/11 at 7:50 PM, with the Assistant Administrator confirmed she had been notified of the allegation. The Assistant Administrator stated she informed the Administrator of the allegation. The Assistant Administrator stated within 30 minutes of being informed of the allegation,</p>	F 223		
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F 223	<p>Continued From page 11</p> <p>SRNA #8 was terminated and removed from the facility. According to the Assistant Administrator, DCBS was notified of the allegation and other state agencies were not notified.</p> <p>An interview conducted on 08/25/11 at 6:05 PM, with the Administrator revealed upon being informed of the allegation on the morning of 08/12/11, SRNA #8 was terminated and escorted off the premises by local Law Enforcement to ensure the safety of residents and staff.</p> <p>An interview conducted on 08/25/11 at 2:50 PM, with SRNA #8 revealed he was told not to kiss or hug the residents. SRNA #8 acknowledged that he had kissed the residents on the cheek and that he had lain in bed with Resident #1.</p> <p>4. In addition, interviews during the state agency's investigation revealed SRNA #8 had a history of inappropriate behaviors:</p> <p>An interview conducted with SRNA #1 on 08/22/11 at 5:20 PM, revealed she witnessed SRNA #8 inappropriately kiss several female residents since 02/11. The SRNA stated she reported SRNA #8's inappropriate behaviors to the charge nurses several times and also reported the SRNA's behaviors to the HRD. According to SRNA #1, LPN #3 instructed SRNA #8 to stop kissing the female residents but the behaviors continued.</p> <p>An interview conducted on 08/23/11 at 2:27 PM, with LPN #3 revealed she had witnessed SRNA #8 kiss several female residents. LPN #3 stated prior to 07/11 she counseled SRNA #8 that kissing on the residents was inappropriate. The</p>	F 223			

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F 223	<p>Continued From page 12</p> <p>LPN stated she reported to the HRD that she observed SRNA #8 inappropriately kiss female residents and was instructed to "counsel" the SRNA if she observed the behavior again.</p> <p>An interview conducted on 08/23/11 at 4:25 PM, with LPN #5 revealed she witnessed SRNA #8 kiss several female residents in an inappropriate manner. LPN #5 stated she and another LPN counseled SRNA #8 about his inappropriate actions in the presence of the HRD. The interview revealed the LPN thought the HRD would inform the DON of SRNA #8's inappropriate behaviors and therefore the LPN did not report the incident to administrative staff.</p> <p>An interview conducted on 08/23/11 at 3:50 PM, with SRNA #6 revealed she witnessed SRNA #8 kiss the female residents on their neck and face in a way that seemed inappropriate. The interview revealed SRNA #6 had not reported the incidents to administrative staff.</p> <p>An interview conducted on 08/23/11 at 3:30 PM, with SRNA #5 revealed she also observed SRNA #8 kiss female residents on their cheeks and close to their mouth. The interview revealed SRNA #5 had not reported the incidents because other staff had also observed incidents and had not reported/stopped them.</p> <p>An interview conducted on 08/22/11 at 4:45 PM, and on 08/24/11 at 6:35 PM, with the HRD revealed she did not recall staff reporting SRNA #8's inappropriate behaviors with female residents prior to 08/12/11. However, the HRD stated that toward the end of 06/11 she witnessed SRNA #8 kiss Resident #4, and she counseled</p>	F 223		

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F 223	<p>Continued From page 13</p> <p>the SRNA concerning his inappropriate behaviors. The interview revealed the HRD had not documented SRNA #8 was counseled but discussed the incident with the DON the next day.</p> <p>An interview conducted on 08/24/11 at 7:05 PM, with the DON revealed she was unaware of SRNA #8's inappropriate behaviors prior the 08/12/11 allegation. Therefore SRNA #8 was not suspended, no investigation was conducted, and the appropriate state agencies were not notified prior to the 08/12/11 allegation.</p> <p>--A review of the Allegation of Compliance revealed the following:</p> <p>The facility terminated SRNA #8 on 08/12/11, when administrative staff was made aware of the allegation involving SRNA #8 and Resident #1.</p> <p>The facility initiated an investigation of the allegation involving SRNA #8 and Resident #1. On 08/12/11, the Assistant Administrator and the HRD conducted interviews with all staff members who may have information regarding the allegation.</p> <p>The facility had nursing staff conduct physical examinations of all residents SRNA #8 had provided care to during the timeframe of 08/06-12/11, to determine if there were any signs/symptoms of abuse.</p> <p>On 08/30/11, RN #1 and LPN #1 conducted interviews with the alert and oriented residents about possible abuse issues.</p> <p>On 08/30/11, the Assistant Administrator and the</p>	F 223			

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F 223	<p>Continued From page 14</p> <p>Co-Owner conducted interviews with 13 family members/visitors, which included family members of non-oriented residents, to determine if there were any signs/symptoms of abuse or any complaints.</p> <p>On 08/25/11, Legal Counsel was contacted concerning the Immediate Jeopardy in abuse investigation, protection, and reporting. Legal Counsel and Administration immediately began review and revisions to the facility's Abuse policy. The final revisions were completed on 08/30/11. Policy changes involved the supervision of staff concerning the supervisory staff's duty to monitor and evaluate the staff that may have greater potential for abuse. The policy instructs staff to advise supervisors of problems dealing with stress. Other policy changes involved the screening procedure to include a screening process for Administration to use upon hire, in addition to the criminal record checks, abuse registry screens, license/certification verification, and reference checks. The investigation section of the policy was also strengthened to ensure all investigations were initiated upon reports of suspected abuse as defined in the Investigation Protocol. The protection section of the policy was revised to state that if a report of abuse was made that involved an employee, that employee would be reassigned from resident care or suspended during the investigation.</p> <p>On 08/25/11 and 08/30/11, the Assistant Administrator and the Administrator received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by Legal Counsel.</p>	F 223		

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F 223	<p>Continued From page 15</p> <p>On 08/26/11, the Education Assistant, the DON, and the Co-Owner received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by the Assistant Administrator.</p> <p>On 08/26/11, training was conducted for all 150 staff members including non-clinical staff during each shift (10 AM, 2 PM, 4 PM, and 11 PM) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner. Upon completion of the training all staff was given a written quiz to verify the staff's comprehension of the material. The facility currently has one staff person on medical leave that will receive this training upon returning to work. All new staff will receive this training upon date of hire. Continued abuse training will be conducted on a bi-annual basis for all staff.</p> <p>On 08/26/11, supervisory staff received specific training on recognizing situations that may indicate stress on staff, because staff working under excessive emotional stress was more likely to be impatient with a greater likelihood of committing abuse. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11 and 08/30/11, all Department Heads received specific training about the new policies/procedures emphasis that potential abuse must be reported to both the OIG and DCBS with the final results of the investigation communicated within five working days. Upon completion of the training all Department Heads</p>	F 223			

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F 223	<p>Continued From page 16</p> <p>were given a written quiz to verify the staff's comprehension of the material. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11, an Abuse Response Checklist File was developed and distributed to the Department Heads to assist the staff in following the correct procedures. The Checklist File consists of the Self Reporting Form published by the OIG.</p> <p>The DON will review compliance with training requirements and will report any and all findings to the Quality Assurance committee on a quarterly basis, which will monitor the facility's compliance.</p> <p>The treatment nurse will monitor residents on a daily basis for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse. The charge nurse is required to report the findings to the DON, who will immediately report to the Assistant Administrator.</p> <p>The Abuse Response Checklist File for the Department Heads will walk the individual through the steps that should be taken when abuse is suspected or reported. All reports of suspected abuse will be immediately reported to the charge nurse. The charge nurse will immediately report the suspected abuse to the DON, who will document the allegation on the 24-hour nurses' report.</p> <p>The DON and the Assistant Administrator will review the 24-hour nurses' report on a daily basis</p>	F 223		

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F 223	<p>Continued From page 17</p> <p>and will report any alleged abuse to the Administrator and the appropriate state agencies. Upon report of any alleged violations the Administration will thoroughly investigate the allegation.</p> <p>The Administrator and the Assistant Administrator will monitor any suspected or actual abuse according to facility policy to ensure the resident is protected by suspending or reassigning the alleged perpetrator, if an employee, during the investigation process. The Administrator and the Assistant Administrator will also monitor that a conclusion to the investigation is completed and that reporting has been made to the appropriate agencies.</p> <p>The Quality Assurance Committee will receive all reports of suspected or actual abuse and will monitor to ensure compliance with facility policy and regulation.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>A review of the Employee Master Change Sheet revealed SRNA #8 was terminated effective 08/12/11, by the Human Resources Director.</p> <p>A review was conducted of the facility's investigation. The investigation was initiated on 08/12/11, when administrative staff received the report of the abuse and SRNA #8 was immediately removed from the facility and escorted off the premises by local Police.</p> <p>A review of the physical examinations of residents cared for by SRNA #8 on 08/06-12/11,</p>	F 223			

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F 223	<p>Continued From page 18</p> <p>was conducted. Skin assessments for eight residents under the care of SRNA #8 were conducted and documented by LPN #3 and each resident was questioned by LPN #8. Interview with LPN #3 on 09/01/11, revealed the LPN conducted the skin assessments at the request of the Human Resources Director after SRNA #8 was escorted from the facility. According to LPN #3, no injuries or skin changes were noted. Skin assessments conducted during the survey revealed no injuries of unknown source. Interviews were conducted with family members of Residents #1 and #4. The family members denied any injuries or mistreatment of the residents.</p> <p>A review of the documentation of interviews with alert/oriented residents and family members conducted by RN #1 revealed no identified problems from the interviews. A resident group interview was conducted by surveyors on 08/30/11 at 10:00 AM, and no reports of abuse/neglect were reported.</p> <p>A review of the facility's revised policy/procedure for abuse/neglect revealed the facility addressed all requirements for the policy/procedure. The revised policy/procedure included education to address staff behaviors that would indicate a potential for abuse. The investigation section of the policy/procedure addressed the need to immediately notify state agencies and reporting requirements for suspected abuse/neglect of residents.</p> <p>Interview on 09/01/11 at 10:35 AM, with the facility's Legal Counsel revealed the Legal Counsel educated the Administrator and</p>	F 223		

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F 223	<p>Continued From page 19</p> <p>Assistant Administrator on abuse/neglect and the regulatory requirements for Long Term Care Facilities from 08/12/11 through 08/30/11. According to Legal Counsel, the Administrator and Assistant Administrator were educated on reporting requirements of suspected abuse and what the definitions for abuse/neglect/misappropriation were. Review of the revised facility policy/procedure revealed the policy met regulatory requirements.</p> <p>A review of the facility's training records revealed evidence that all employees of the facility except for one received training on abuse/neglect from administrative staff on 08/26/11. One facility employee was on medical leave and will be educated prior to being allowed to work. The attendance rosters for the training were compared to the facility's time reports for active working employees and confirmed all employees received education in abuse/neglect and received a copy of the facility policy/procedure. The facility's documentation included evidence of each staff member having successfully passed a quiz concerning the information given in the abuse/neglect training. Staff interviews were conducted on 08/31/11 from 3:40 PM to 4:30 PM, and on 09/01/11 at 11:42 AM, with LPN #11, LPN #12, KMA #2, SRNA #14, SRNA #15, Housekeeper #1, and Housekeeper #2 related to the facility's abuse/neglect training. Staff verified the receipt of training and each received a copy of the facility's revised policy/procedure.</p> <p>A review of the facility's training records revealed evidence the facility's Department Heads received training in abuse/neglect and reporting. The Checklist File was included in the facility's</p>	F 223		

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F 223	Continued From page 20 documentation. A review of the facility's 24-hour Nursing Report, used as the monitoring tool for signs of abuse, revealed documentation of daily monitoring of residents including any changes in condition or new orders. Interview with the Assistant Administrator on 09/01/11 at 11:10 AM, revealed the 24-hour Nursing Report was reviewed on a daily basis and any concerns were investigated. The Assistant Administrator stated the results of the monitoring would be part of the facility's Quality Assurance process. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systematic changes and quality assurance activities.	F 223			
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225			

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F 225	<p>Continued From page 21</p> <p>including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation and policies, it was determined the facility failed to have an effective system in place to ensure all allegations of abuse were immediately reported to administrative staff and to the appropriate state agencies. A review of documentation and interviews conducted revealed facility staff became aware that an employee of the building had exhibited abusive behavior toward two (2) of twenty-two (22) sampled residents (Resident #1 and #2). The facility failed to ensure allegations of abuse were immediately reported to the appropriate state agencies. The facility also failed to protect</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>residents from abuse by allowing an alleged perpetrator to continue to work after an allegation of abuse had been reported, and failed to conduct a thorough investigation of a reported abuse allegation.</p> <p>The facility's failure to ensure staff immediately reported all allegations of abuse to administrative staff and the appropriate state agencies, failure to protect residents from abuse during the facility's investigation, and failure to conduct a thorough investigation has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1, Resident #2, and other residents in the facility. Immediate Jeopardy and Substandard Quality of Care (SQC) were determined to exist on 07/19/11. (Refer to F223.)</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/31/11, which alleged removal of Immediate Jeopardy on 08/31/11. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Abuse Policy (revised 09/06/00) revealed, "In the event of any evidence to cause to believe that a resident has suffered any abuse, the employee, visitor or family member are requested to report any/all allegations, suspicion, or incidents to the administration of the facility, i.e. charge nurses, supervisors, DON, SSD, or administrator." The policy revealed, "Upon report of any allegations or</p>	F 225			

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F 225	<p>Continued From page 23</p> <p>violations, the administration will thoroughly investigate the situation. Any employee suspected of abuse, neglect, or disregard for resident welfare will be suspended from direct resident care while the investigation is in progress." The review revealed the investigation would include, but not be limited to, the following: names of all individuals involved, witnesses that actually viewed the incident, the resident's/family's statement concerning the incident, when and where the incident occurred, and any evidence of injury or abuse present on the resident's body or in the resident's actions. The policy revealed, "The results of the investigation shall be documented and place in the investigation file." The policy also revealed, "After knowledge of an allegation of abuse, the administrator, director of nursing or social service director shall report it to Adult Protective Services and the Cabinet for Human Resources immediately. The results of all investigations will be reported to the same agencies within five (5) working days of the incident."</p> <p>1. An interview conducted on 08/22/11 at 2:45 PM, with Certified Medication Aide (CMA) #1 revealed on 07/19/11, she witnessed State Registered Nurse Aide (SRNA) #8 being physically, mentally, and verbally rough with Resident #2 and Resident #8. The CMA reported SRNA #8's behavior to the Director of Nursing (DON) the next morning on 07/20/11. Interview on 08/24/11 at 7:05 PM, with the DON revealed she did not recall CMA #1's allegation against SRNA #8. Therefore, SRNA #8 was not suspended, no investigation was conducted, and the appropriate state agencies were not notified.</p>	F 225		

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F 225	<p>Continued From page 24</p> <p>An interview conducted on 08/22/11 at 5:20 PM, with State Registered Nurse Aide (SRNA) #1 revealed SRNA #8 had a history of being rude and threatened/intimidated Resident #2 by saying to the resident, "You apologize or else," "No, you're not getting up," and would refuse to transfer the resident to the chair. According to SRNA #1, she could not remember when she witnessed this incident but she did report SRNA #8's behaviors to the Human Resources Director (HRD). Interview on 08/24/11 at 6:35 PM, with the HRD revealed she did not recall SRNA #1's allegation against SRNA #8. Therefore SRNA #8 was not suspended, no investigation was conducted, and the appropriate state agencies were not notified.</p> <p>Interviews conducted on 08/22/11 at 7:00 PM, with the Assistant Administrator, and on 08/25/11 at 6:05 PM, with the Administrator revealed they were unaware of the above allegations against SRNA #8.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 09/14/10, with diagnoses of Schizophrenia, Close Head Injury, Depression, and Left Sided Weakness. A review of Resident #2's Quarterly Minimum Data Set (MDS) assessment dated 08/15/11, revealed the resident's cognition was intact and the resident required extensive assistance of two staff persons with bed mobility, transfers, dressing and toileting.</p> <p>A review of an investigative report, undated and provided by the facility, revealed statements had been obtained from eight employees, the DON, and an alleged perpetrator related to an allegation</p>	F 225		

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F 225	<p>Continued From page 25</p> <p>made by Resident #2 that SRNA #8 had "beat" the resident on the evening of 07/20/11.</p> <p>An interview conducted on 08/22/11 at 6:15 PM, with Resident #2 revealed SRNA #8 was not good to the resident. Resident #2 stated, "He tried to kill me." Resident #2 stated SRNA #8 had placed a pillow over the resident's face and "tried to smother me." The resident stated SRNA #8 "hit me four times," and indicated SRNA #8 had hit the resident two times on each side of the head.</p> <p>Interviews conducted on 08/22/11 at 2:11 PM, with the Minimum Data Set (MDS) Coordinator, on 08/22/11 at 3:30 PM, with Registered Nurse (RN) #1, and on 08/22/11 at 2:45 PM, with Certified Medication Aide (CMA) #1 revealed on the morning of 07/21/11, Resident #2 reported that SRNA #8 put a pillow over the resident's face and hit the resident on the resident's head four times. CMA #1 stated a small bruise was noted to the left side of the resident's face that was not present the previous day. The interviews revealed the staff reported Resident #2's allegation to the DON and the HRD.</p> <p>An interview conducted on 08/22/11 at 6:30 PM, and on 08/24/11 at 7:05 PM, with the DON and a review of documentation revealed Resident #2 informed the DON at approximately 10:55 AM on 07/21/11, that SRNA #8 "put a pillow over my face and then hit me on each side of my head," and asked, "What are you going to do about" SRNA #8. The DON revealed the Administrator was notified of the allegation at approximately 8:20 AM on 07/21/11, and stated, "Not to report as this didn't happen." On 07/21/11 at 12:10 PM,</p>	F 225		

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F 225	<p>Continued From page 26</p> <p>the DON reported the allegation again to the Administrator and was told, "Quit worrying about this;" the resident is "crazy." The DON stated the Assistant Administrator notified the Department for Community Based Services (DCBS) of the resident's allegation on 07/25/11.</p> <p>An interview conducted on 08/22/11 at 7:00 PM, with the Assistant Administrator revealed SRNA #8 continued to work on 07/22/11, 07/23/11, and 07/24/11, until the Assistant Administrator returned from vacation and was informed of the allegation. The Assistant Administrator stated due to Resident #3's history of head injury and because the resident recanted the allegation the facility felt the allegation was not true and did not need to be reported to the state survey and certification agency.</p> <p>An interview conducted on 08/25/11 at 6:05 PM, with the Administrator revealed the Administrator was informed of Resident #2's allegation on 07/21/11, and due to the resident being "delusional" the allegation was not reported to the state agencies.</p> <p>3. The facility admitted Resident #1 on 11/06/09. A review of Resident #1's comprehensive Annual Minimum Data Set (MDS) assessment dated 11/13/10 revealed the resident's cognition was severely impaired and the resident was independent with no setup needed for transfers, dressing, toileting, and hygiene.</p> <p>An interview conducted on 08/23/11 at 10:10 AM, with SRNA #2 revealed on 08/10/11, during the 7 AM-3 PM shift, SRNA #8 came into Resident #1's room, lay down on the bed, and "spooned" the</p>	F 225		

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F 225	<p>Continued From page 27</p> <p>resident. SRNA #2 completed her duties and then reported her observation to her supervisor (Restorative Aide #2) within ten minutes. However, an interview conducted on 08/25/11 at 8:10 AM, with Restorative Aide (RA) #2 revealed she did not report the allegation to administrative staff because she thought the report was a rumor.</p> <p>An interview conducted on 08/22/11 at 3:11 PM, with SRNA #7 revealed while providing care to Resident #3, SRNA #2 informed SRNA #7 of the allegation that SRNA #8 had been in the bed with a female resident. SRNA #7 stated she thought the allegation had already been reported and therefore did not report the allegation to administrative staff.</p> <p>An interview conducted on 08/24/11 at 5:15 PM, with LPN #6 revealed she was informed at approximately 6:45 AM on 08/11/11, by SRNA #9 that Resident #3 reported SRNA #8 was caught in bed with a female resident. LPN #6 went home and returned to work that same day at 7:00 PM, at which time she informed LPN #2 of the allegation. LPN #6 waited 26 hours after being informed of the allegation on 08/11/11, to report the allegation to the Human Resources Director (HRD) on 08/12/11.</p> <p>An interview conducted on 08/22/11 at 4:05 PM, with LPN #2 revealed she did not report the allegation to administrative staff as required because LPN #6 was initially informed of the allegation.</p> <p>Interviews conducted on 08/22/11 at 2:11 PM, with the MDS Coordinator and on 08/22/11 at</p>	F 225		

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F 225	<p>Continued From page 28</p> <p>4:45 PM, with the HRD revealed on 08/12/11, at approximately 8:30 AM, they were informed of the allegation. At that time, the Assistant Administrator and the Administrator were informed of the allegation, Law Enforcement was notified, and SRNA #8 was escorted off the premises.</p> <p>Interviews conducted on 08/22/11 at 7:00 PM, and 08/24/11 at 7:50 PM, with the Assistant Administrator, and on 08/25/11 at 6:05 PM, with the Administrator revealed on 08/12/11 at approximately 10:30 AM, they were notified of the allegation that SRNA #8 had been in the bed of a female resident. The interviews revealed at that time SRNA #8 was terminated and removed from the facility. The Assistant Administrator confirmed the state survey and certification agency was not notified of this allegation.</p> <p>A review of the facility's investigation, undated, involving SRNA #8 lying on the bed and spooning Resident #1 revealed statements were obtained, however, the appropriate state agencies had not been notified of the allegation.</p> <p>4. In addition, based on interviews, SRNA #8 exhibited a history of unacceptable behaviors that facility staff failed to report. Interviews conducted on 08/22/11 at 5:20 PM, with SRNA #1, on 08/23/11 at 2:27 PM, with LPN #3, and on 08/23/11 at 4:25 PM, with LPN #5 revealed the staff had witnessed SRNA #8 inappropriately kiss several female residents and reported SRNA #8's inappropriate behaviors to the charge nurses, the HRD, and the DON prior to 07/11. There was no documented evidence that these allegations were thoroughly investigated, reported to the</p>	F 225		

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F 225	<p>Continued From page 29 Administrator, or the appropriate state agencies.</p> <p>Interviews conducted on 08/23/11 at 3:50 PM, with SRNA #6 and on 08/23/11 at 3:30 PM, with SRNA #5 revealed SRNA #8 would kiss on the female residents in a way that seemed inappropriate. SRNA #6 stated Resident #8 would scream hysterically when SRNA #8 came into the resident's room. However, these allegations were not reported to administrative staff because the nurses had already asked SRNA #8 to stop this behavior, according to SRNA #6.</p> <p>An interview conducted on 08/22/11 at 4:45 PM, and on 08/24/11 at 6:35 PM, with the HRD revealed she did not recall staff had reported SRNA #8's inappropriate behaviors with female residents prior to 08/12/11. However, the HRD stated that toward the end of 06/11, she witnessed SRNA #8 kiss Resident #4 and she "counseled" the SRNA concerning his inappropriate behaviors. There was no documentation provided that the HRD had "counseled" SRNA #8 or that the allegation was thoroughly investigated and reported to the Administrator or the appropriate state agencies.</p> <p>An interview conducted on 08/24/11 at 7:05 PM, with the DON revealed she did not recall that staff had informed her of SRNA #8's inappropriate behaviors prior to the 08/12/11 allegation.</p> <p>—A review of the Allegation of Compliance revealed the following:</p> <p>The facility terminated SRNA #8 on 08/12/11, when administrative staff was made aware of the</p>	F 225			

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F 225	<p>Continued From page 30 allegation involving SRNA #8 and Resident #1.</p> <p>The facility initiated an investigation of the allegation involving SRNA #8 and Resident #1. On 08/12/11, the Assistant Administrator and the HRD conducted interviews with all staff members who may have information regarding the allegation.</p> <p>The facility had nursing staff conduct physical examinations of all residents SRNA #8 had provided care to during the timeframe of 08/06/11 through 08/12/11, to determine if there were any signs/symptoms of abuse.</p> <p>On 08/30/11, RN #1 and LPN #1 conducted interviews with the alert and oriented residents about possible abuse issues.</p> <p>On 08/30/11, the Assistant Administrator and the Co-Owner conducted interviews with 13 family members/visitors, which included family members of non-oriented residents to determine if there were any signs/symptoms of abuse or any complaints.</p> <p>On 08/25/11, Legal Counsel was contacted concerning the Immediate Jeopardy in abuse investigation, protection, and reporting. Legal Counsel and Administration immediately began review and revisions to the facility's Abuse policy. The final revisions were completed on 08/30/11. Policy changes involved the supervision of staff concerning the supervisory staff's duty to monitor and evaluate the staff that may have greater potential for abuse. The policy instructs staff to advise supervisors of problems dealing with stress. Other policy changes involved the</p>	F 225			

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F 225	<p>Continued From page 31.</p> <p>screening procedure to include a screening process for administration to use upon hire, in addition to the criminal record checks, abuse registry screens, license/certification verification, and reference checks. The investigation section of the policy was also strengthened to ensure investigations are initiated upon reports of suspected abuse as defined in the Investigation Protocol. The protection section of the policy was revised to state that if a report of abuse is made that involves an employee, that employee will be reassigned from resident care or suspended during the investigation.</p> <p>On 08/25/11 and 08/30/11, the Assistant Administrator and the Administrator received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by Legal Counsel.</p> <p>On 08/26/11, the Education Assistant, the DON, and the Co-Owner received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by the Assistant Administrator.</p> <p>On 08/26/11, training was conducted for all 150 staff members including non-clinical staff during each shift (10 AM, 2 PM, 4 PM, and 11 PM) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner. Upon completion of the training all staff was given a written quiz to verify the staff's comprehension of the material. The facility currently has one staff person on medical leave that will receive this training upon returning to work. All new staff will</p>	F 225		

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F 225	<p>Continued From page 32</p> <p>receive this training upon date of hire. Continued abuse training will be conducted on a bi-annual basis for all staff.</p> <p>On 08/26/11, supervisory staff received specific training on recognizing situations that may indicate stress on staff because staff working under excessive emotional stress was more likely to be impatient with a greater likelihood of committing abuse. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11 and 08/30/11, all Department Heads received specific training about the new policies/procedures emphasizing that potential abuse must be reported to both the OIG and DCBS with the final results of the investigation communicated within five working days. Upon completion of the training all Department Heads were given a written quiz to verify the staff's comprehension of the material. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11, an Abuse Response Checklist File was developed and distributed to the Department Heads to assist the staff in following the correct procedures. The Checklist File consists of the Self Reporting Form published by the OIG.</p> <p>The DON will review compliance with training requirements and will report any and all findings to the Quality Assurance committee on a quarterly basis, which will monitor the facility's compliance.</p> <p>The treatment nurse will monitor residents on a</p>	F 225			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/01/2011
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423		
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F 225	<p>Continued From page 33</p> <p>daily basis for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse. The charge nurse is required to report the findings to the DON, who will immediately report to the Assistant Administrator.</p> <p>The Abuse Response Checklist File for the Department Heads will walk the individual through the steps that should be taken when abuse is suspected or reported. All reports of suspected abuse will be immediately reported to the charge nurse. The charge nurse will immediately report the suspected abuse to the DON, who will document the allegation on the 24-hour nurses' report.</p> <p>The DON and the Assistant Administrator will review the 24-hour nurses' report on a daily basis and will report any alleged abuse to the Administrator and the appropriate state agencies. Upon report of any alleged violations the Administration will thoroughly investigate the allegation.</p> <p>The Administrator and the Assistant Administrator will monitor any suspected or actual abuse according to facility policy to ensure the resident is protected by suspending or reassigning the alleged perpetrator, if an employee, during the investigation process. The Administrator and the Assistant Administrator will also monitor that a conclusion to the investigation is completed and that reporting has been made to the appropriate agencies.</p> <p>The Quality Assurance Committee will receive all</p>	F 225		

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F 225	<p>Continued From page 34</p> <p>reports of suspected or actual abuse and will monitor to ensure compliance with facility policy and regulation.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>A review of the Employee Master Change Sheet revealed SRNA #8 was terminated effective 08/12/11, by the Human Resources Director.</p> <p>A review was conducted of the facility's investigation. The investigation was initiated on 08/12/11, when administrative staff received the report of the abuse and SRNA #8 was immediately removed from the facility and escorted off the premises by local Police.</p> <p>A review of the physical examinations of residents cared for by SRNA #8 on 08/06/11 through 08/12/11, was conducted. Skin assessments for eight residents under the care of SRNA #8 were conducted and documented by LPN #3 and each resident was questioned by LPN #8. Interview with LPN #3 on 09/01/11, revealed the LPN conducted the skin assessments at the request of the Human Resources Director after SRNA #8 was escorted from the facility. According to LPN #3, no injuries or skin changes were noted. Skin assessments conducted during the survey revealed no injuries of unknown source. Interviews were conducted with family members of Residents #1 and #4. The family members denied any injuries or mistreatment of the residents.</p> <p>A review of the documentation of interviews with alert/oriented residents and family members</p>	F 225			

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F 225	<p>Continued From page 35</p> <p>conducted by RN #1 revealed no identified problems from the interviews. A resident group interview was conducted by surveyors on 08/30/11 at 10:00 AM, and no reports of abuse/neglect were reported.</p> <p>A review of the facility's revised policy/procedure for abuse/neglect revealed the facility had addressed all requirements for the policy/procedure. The revised policy/procedure included education to address staff behaviors that would indicate a potential for abuse. The investigation section of the policy/procedure addressed the need to immediately notify state agencies and reporting requirements for suspected abuse/neglect of residents.</p> <p>Interview on 09/01/11 at 10:35 AM, with the facility's Legal Counsel revealed the Legal Counsel had educated the Administrator and Assistant Administrator on abuse/neglect and the regulatory requirements for Long Term Care Facilities from 08/12/11 through 08/30/11. According to Legal Counsel, the Administrator and Assistant Administrator were educated on reporting requirements of suspected abuse and what the definitions for abuse/neglect/misappropriation were. Review of the revised facility policy/procedure revealed the policy met regulatory requirements.</p> <p>A review of the facility's training records revealed evidence that all employees of the facility except for one received training on abuse/neglect from administrative staff on 08/26/11. One facility employee was on medical leave and will be educated prior to being allowed to work. The attendance rosters for the training were</p>	F 225		

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F 225	<p>Continued From page 36</p> <p>compared to the facility's time reports for active working employees and confirmed all employees received education in abuse/neglect and had received a copy of the facility policy/procedure. The facility's documentation included evidence of each staff member having successfully passed a quiz concerning the information given in the abuse/neglect training. Staff interviews were conducted on 08/31/11 from 3:40 PM to 4:30 PM, and on 09/01/11 at 11:42 AM, of LPN #11, LPN #12, KMA #2, SRNA #14, SRNA #15, Housekeeper #1, and Housekeeper #2 related to the facility's abuse/neglect training. Staff verified the receipt of training and each had received a copy of the facility's revised policy/procedure.</p> <p>A review of the facility's training records revealed evidence the facility's Department Heads had received training in abuse/neglect and reporting. The Checklist File was included in the facility's documentation.</p> <p>A review of the facility's 24-hour Nursing Report, used as the monitoring tool for signs of abuse, revealed documentation of daily monitoring of residents including any changes in condition or new orders. Interview with the Assistant Administrator on 09/01/11 at 11:10 AM, revealed the 24-hour Nursing Report was reviewed on a daily basis and any concerns were investigated. The Assistant Administrator stated the results of the monitoring would be part of the facility's Quality Assurance process.</p> <p>The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the</p>	F 225			

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F 225	Continued From page 37 systematic changes and quality assurance activities.	F 225		
F 226 SS=K	<p>483.13(c) DEVELOP/IMPLMENT 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: Based on interview, record review, facility investigation review, and facility policies review, it was determined the facility failed to ensure the facility's policy/procedures were implemented related to abuse, neglect, and mistreatment for two (2) of twenty-two (22) sampled residents (Residents #1 and #2). The facility failed to ensure all allegations of abuse were reported immediately to administrative staff and the appropriate state agencies as per policy, failed to protect residents from abuse, and failed to thoroughly investigate all allegations of abuse.</p> <p>On 07/19/11, SRNA #8 was observed to be physically and verbally abusive to Resident #2 and, based on interviews, the allegation was reported to the DON; however, the DON denied the report. Resident #2 reported on 07/21/11, SRNA #8 abused the resident the previous evening. The allegation was reported to the DON.</p> <p>On 08/10/11, SRNA #2 witnessed and reported SRNA #8 lay in the bed and "spooned" Resident #1. In addition, interviews revealed throughout</p>	F 226		

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F 226	<p>Continued From page 38</p> <p>SRNA #8's employment staff witnessed SRNA #8 inappropriately kiss female residents and reported SRNA #8's behaviors to the DON and the Human Resources Director (HRD). (Refer to F223 and F225.)</p> <p>The facility's failure to implement the policies related to abuse has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and Resident #2 and other residents in the facility. Immediate Jeopardy and Substandard Quality of Care (SQC) were determined to exist on 07/19/11.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/31/11, which alleged removal of Immediate Jeopardy on 08/31/11. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Abuse Policy (revised 09/06/00) revealed, "In the event of any evidence to cause to believe that a resident has suffered any abuse, the employee, visitor or family member are requested to report any/all allegations, suspicion, or incidents to the administration of the facility, i.e. charge nurses, supervisors, DON, SSD, or administrator." According to the policy, "Upon report of any allegations or violations, the administration will thoroughly investigate the situation. Any employee suspected of abuse, neglect, or disregard for resident welfare will be suspended</p>	F 226			

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F 226	<p>Continued From page 39</p> <p>from direct resident care while the investigation is in progress." The review revealed the investigation would include, but not be limited to, the following: names of all individuals involved, witnesses that actually viewed the incident, the resident's/family's statement concerning the incident, when and where the incident occurred, and any evidence of injury or abuse present on the resident's body or in the resident's actions. In addition, the policy revealed, "The results of the investigation shall be documented and placed in the investigation file." The policy also revealed, "After knowledge of an allegation of abuse, the administrator, director of nursing or social service director shall report it to Adult Protective Services and the Cabinet for Human Resources immediately. The results of all investigations will be reported to the same agencies within five (5) working days of the incident."</p> <p>1. An interview conducted on 08/22/11 at 2:45 PM, with Certified Medication Aide (CMA) #1 revealed on 07/19/11, she witnessed State Registered Nurse Aide (SRNA) #8 being physically, mentally, and verbally rough with Resident #2 and Resident #8. The CMA reported SRNA #8's behavior to the Director of Nursing (DON) the next morning on 07/20/11. Interview on 08/24/11 at 7:05 PM, with the DON revealed she did not recall CMA #1's allegation against SRNA #8. Therefore SRNA #8 was not suspended, no investigation was conducted, and the appropriate state agencies were not notified.</p> <p>2. An interview conducted on 08/22/11 at 6:15 PM, with Resident #2 revealed SRNA #8 was not good to the resident. Resident #2 stated, "He tried to kill me," had placed a pillow over the</p>	F 226		

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F 226	<p>Continued From page 40</p> <p>resident's face, and "tried to smother me." The resident stated SRNA #8 "hit me four times," two times on each side of the resident's head. The interview revealed this was the only time SRNA #8 physically abused the resident. A review of the facility's investigation of Resident #2's allegation revealed staff reported Resident #2 said SRNA #8 "beat" up the resident. The investigation included staff statements; however, there was no documentation of the investigative findings, a conclusion, or that the appropriate state agencies had been notified of the allegation as per policy. The review revealed SRNA #8 continued to provide direct care to the residents for three days following the allegation made by Resident #2 on 07/21/11.</p> <p>An interview conducted on 08/22/11 at 2:45 PM, with Certified Medication Aide (CMA) #1 revealed on 07/19/11, she witnessed SRNA #8 being physically, mentally, and verbally rough with Resident #2 and Resident #8 and reported SRNA #8's behavior to the charge nurse that night (07/19/11) and to the DON the next morning (07/20/11). However, there was no documentation the facility implemented the Abuse policy by conducting an investigation or reporting the allegation to the appropriate state agencies.</p> <p>An interview conducted on 08/22/11 at 5:20 PM, with SRNA #1 revealed SRNA #8 was rude and threatened/intimidated Resident #2 by saying to the resident, "You apologize or else," "No, you're not getting up," and refused to transfer the resident to the chair. SRNA #1 did not report this allegation to administrative staff in accordance with facility policy. Therefore, the allegation was not investigated or reported to the appropriate</p>	F 226		

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F 226	<p>Continued From page 41 state agencies.</p> <p>A review of the facility's investigation of Resident #2's allegation revealed staff reported Resident #2 said SRNA #8 "beat" up the resident. The investigation included staff statements; however, there was no documentation of a conclusion or results of investigative findings or that the appropriate state agencies were notified of the allegation in accordance with facility policy.</p> <p>An interview conducted on 08/22/11 at 6:30 PM, and on 08/24/11 at 7:05 PM, with the DON revealed on the morning of 07/21/11, staff reported Resident #2 had made an allegation that SRNA #8 had beat the resident up. The DON informed the Administrator and was instructed not to report the allegation. According to the DON, and an interview conducted on 08/22/11 at 7:00 PM, with the Assistant Administrator, SRNA #8 continued to work on 07/22/11, 07/23/11, and 07/24/11, after the allegation was reported and had not been suspended in accordance with facility policy. In addition, the DON confirmed there were no results to the facility's investigation or that the allegation had been reported to the state survey and certification agency in accordance with facility policy.</p> <p>An interview conducted on 08/25/11 at 6:05 PM, with the Administrator revealed Resident #2 was "delusional" so the allegation was not reported to all state agencies per policy.</p> <p>3. An interview conducted on 08/23/11 at 10:10 AM, with SRNA #2 revealed on 08/10/11, she witnessed SRNA #8 come into Resident #1's room, lie down on the bed with the resident,</p>	F 226		

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F 226	<p>Continued From page 42</p> <p>"spoon" and kiss the resident, and leave the room. SRNA #2 reported the allegation to her supervisor (RA #2). An interview conducted on 08/25/11 at 8:10 AM, with RA #2 revealed she did not report the allegation to administrative staff.</p> <p>An interview conducted on 08/29/11 at 4:30 PM, with SRNA #9 revealed on 08/11/11, Resident #3 told her SRNA #8 was observed to be lying on top of a 90-year-old woman. The interview revealed SRNA #9 immediately reported the allegation to LPN #6. An interview conducted on 08/24/11 at 5:15 PM, with LPN #6 revealed she was informed of the allegation at approximately 6:45 AM on 08/11/11. LPN #6 waited approximately 26 hours before reporting the allegation to the HRD the next morning on 08/12/11.</p> <p>A review of the facility's investigation involving SRNA #8 spooning with Resident #1 revealed there was no documentation of results of investigative findings or that all the appropriate state agencies had been notified of the allegation as per policy.</p> <p>4. Additional information addressing SRNA #8's history of abusive behaviors was obtained during interviews:</p> <p>An interview conducted on 08/22/11 at 5:20 PM, with SRNA #1 revealed since 02/11 she had witnessed SRNA #8 inappropriately kiss several female residents and had reported the behaviors to the charge nurses and the HRD several times. There was no documentation this allegation was investigated or reported to the appropriate state agencies as per policy.</p>	F 226		

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F 226	<p>Continued From page 43</p> <p>Interviews conducted on 08/23/11 at 3:50 PM, with SRNA #6, and on 08/23/11 at 3:30 PM, with SRNA #5 revealed SRNA #8 kissed the female residents inappropriately. SRNA #6 stated Resident #8 would scream hysterically when SRNA #8 came into the resident's room. The interviews revealed neither SRNA reported SRNA #8's inappropriate behaviors to administrative staff (charge nurses, supervisors, DON, SSD, or Administrator) as required by facility policy.</p> <p>Interviews conducted on 08/23/11 at 2:27 PM, with LPN #3, and on 08/23/11 at 4:25 PM, with LPN #5 also revealed the LPNs had witnessed SRNA #8 kiss several female residents. The interviews revealed prior to 07/11, both LPNs had separately "counseled" SRNA #8 and informed the SRNA that it was inappropriate to kiss the residents. LPN #3 stated she reported the SRNA's behaviors to the HRD on two occasions. LPN #5 stated she counseled SRNA #8 about his inappropriate behavior in the presence of the HRD. LPN #5 thought the HRD would inform the DON of SRNA #8's inappropriate behaviors. There was no documentation these allegations were reported to administrative staff (charge nurses, supervisors, DON, SSD, or Administrator), investigated, or reported to the appropriate state agencies as per policy.</p> <p>An interview conducted on 08/22/11 at 4:45 PM, and on 08/24/11 at 6:35 PM, with the HRD revealed staff had not reported SRNA #8's actions to her prior to 08/12/11. The HRD stated that in 06/11 she witnessed SRNA #8 kiss Resident #4, and had counseled the SRNA. The interview revealed the HRD discussed the SRNA's behaviors with the DON the next day.</p>	F 226		

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F 226	<p>Continued From page 44</p> <p>There was no documentation this allegation was investigated or reported to the appropriate state agencies as per policy.</p> <p>An interview conducted on 08/24/11 at 7:05 PM, with the DON revealed she had not been informed of SRNA #8's inappropriate behaviors prior to the 08/12/11 allegation. Therefore, there were no investigations conducted.</p> <p>--A review of the Allegation of Compliance revealed the following:</p> <p>The facility terminated SRNA #8 on 08/12/11, when administrative staff was made aware of the allegation involving SRNA #8 and Resident #1.</p> <p>The facility initiated an investigation of the allegation involving SRNA #8 and Resident #1. On 08/12/11, the Assistant Administrator and the HRD conducted interviews with all staff members who may have information regarding the allegation.</p> <p>The facility had nursing staff conduct physical examinations of all residents SRNA #8 had provided care to during the timeframe of 08/06/11 through 08/12/11, to determine if there were any signs/symptoms of abuse.</p> <p>On 08/30/11, RN #1 and LPN #1 conducted interviews with the alert and oriented residents about possible abuse issues.</p> <p>On 08/30/11, the Assistant Administrator and the Co-Owner conducted interviews with 13 family members/visitors, which included family members of non-oriented residents to determine if there</p>	F 226		

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F 226	<p>Continued From page 45</p> <p>were any signs/symptoms of abuse or any complaints.</p> <p>On 08/25/11, Legal Counsel was contacted concerning the Immediate Jeopardy in abuse investigation, protection, and reporting. Legal Counsel and Administration immediately began review and revisions to the facility's Abuse policy. The final revisions were completed on 08/30/11. Policy changes involved the supervision of staff concerning the supervisory staff's duty to monitor and evaluate the staff that may have greater potential for abuse. The policy instructs staff to advise supervisors of problems dealing with stress. Other policy changes involved the screening procedure to include a screening process for Administration to use upon hire, in addition to the criminal record checks, abuse registry screens, license/certification verification, and reference checks. The investigation section of the policy was also strengthened to ensure investigations are initiated upon reports of suspected abuse as defined in the Investigation Protocol. The protection section of the policy was revised to state that if a report of abuse is made that involves an employee, that employee will be reassigned from resident care or suspended during the investigation.</p> <p>On 08/25/11 and 08/30/11, the Assistant Administrator and the Administrator received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by Legal Counsel.</p> <p>On 08/26/11, the Education Assistant, the DON, and the Co-Owner received training concerning abuse prevention, abuse protection, abuse</p>	F 226		

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F 226	<p>Continued From page 46 investigation, and abuse reporting by the Assistant Administrator.</p> <p>On 08/26/11, training was conducted for all 150 staff members including non-clinical staff during each shift (10 AM, 2 PM, 4 PM, and 11 PM) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner. Upon completion of the training all staff was given a written quiz to verify the staff's comprehension of the material. The facility currently has one staff person on medical leave that will receive this training upon returning to work. All new staff will receive this training upon date of hire. Continued abuse training will be conducted on a bi-annual basis for all staff.</p> <p>On 08/26/11, supervisory staff received specific training on recognizing situations that may indicate stress on staff because staff working under excessive emotional stress was more likely to be impatient with a greater likelihood of committing abuse. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11 and 08/30/11, all Department Heads received specific training about the new policies/procedures emphasizing that potential abuse must be reported to both the OIG and DCBS with the final results of the investigation communicated within five working days. Upon completion of the training all Department Heads were given a written quiz to verify the staff's comprehension of the material. The training was conducted by the Education Assistant, the</p>	F 226			

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F 226	<p>Continued From page 47 Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11, an Abuse Response Checklist File was developed and distributed to the Department Heads to assist the staff in following the correct procedures. The Checklist File consists of the Self Reporting Form published by the OIG.</p> <p>The DON will review compliance with training requirements and will report any and all findings to the Quality Assurance committee on a quarterly basis, which will monitor the facility's compliance.</p> <p>The treatment nurse will monitor residents on a daily basis for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse. The charge nurse is required to report the findings to the DON, who will immediately report to the Assistant Administrator.</p> <p>The Abuse Response Checklist File for the Department Heads will walk the individual through the steps that should be taken when abuse is suspected or reported. All reports of suspected abuse will be immediately reported to the charge nurse. The charge nurse will immediately report the suspected abuse to the DON, who will document the allegation on the 24-hour nurses' report.</p> <p>The DON and the Assistant Administrator will review the 24-hour nurses' report on a daily basis and will report any alleged abuse to the Administrator and the appropriate state agencies. Upon report of any alleged violations the</p>	F 226			

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F 226	<p>Continued From page 48</p> <p>Administration will thoroughly investigate the allegation.</p> <p>The Administrator and the Assistant Administrator will monitor any suspected or actual abuse according to facility policy to ensure the resident is protected by suspending or reassigning the alleged perpetrator, if an employee, during the investigation process. The Administrator and the Assistant Administrator will also monitor that a conclusion to the investigation is completed and that reporting has been made to the appropriate agencies.</p> <p>The Quality Assurance Committee will receive all reports of suspected or actual abuse and will monitor to ensure compliance with facility policy and regulation.</p> <p>—The surveyors validated the corrective actions taken by the facility as follows:</p> <p>A review of the Employee Master Change Sheet revealed SRNA #8 was terminated effective 08/12/11, by the Human Resources Director.</p> <p>A review was conducted of the facility's investigation. The investigation was initiated on 08/12/11, when administrative staff received the report of the abuse and SRNA #8 was immediately removed from the facility and escorted off the premises by local Police.</p> <p>A review of the physical examinations of residents cared for by SRNA #8 on 08/06/11 through 08/12/11, was conducted. Skin assessments for eight residents under the care of SRNA #8 were conducted and documented by</p>	F 226		

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F 226	<p>Continued From page 49</p> <p>LPN #3 and each resident was questioned by LPN #8. Interview with LPN #3 on 09/01/11, revealed the LPN had conducted the skin assessments at the request of the Human Resources Director after SRNA #8 was escorted from the facility. According to LPN #3, no injuries or skin changes were noted. Skin assessments conducted during the survey revealed no injuries of unknown source. Interviews were conducted with family members of Residents #1 and #4. The family members denied any injuries or mistreatment of the residents.</p> <p>A review of the documentation of interviews with alert/oriented residents and family members conducted by RN #1 revealed no identified problems from the interviews. A resident group interview was conducted by surveyors on 08/30/11 at 10:00 AM, and no reports of abuse/neglect were reported.</p> <p>A review of the facility's revised policy/procedure for abuse/neglect revealed the facility had addressed all requirements for the policy/procedure. The revised policy/procedure included education to address staff behaviors that would indicate a potential for abuse. The investigation section of the policy/procedure addressed the need to immediately notify state agencies and reporting requirements for suspected abuse/neglect of residents.</p> <p>Interview on 09/01/11 at 10:35 AM, with the facility's Legal Counsel revealed the Legal Counsel had educated the Administrator and Assistant Administrator on abuse/neglect and the regulatory requirements for Long Term Care Facilities from 08/12/11 through 08/30/11.</p>	F 226		

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F 226	<p>Continued From page 50</p> <p>According to Legal Counsel, the Administrator and Assistant Administrator were educated on reporting requirements of suspected abuse and what the definitions for abuse/neglect/misappropriation were. Review of the revised facility policy/procedure revealed the policy met regulatory requirements.</p> <p>A review of the facility's training records revealed evidence that all employees of the facility except for one had received training on abuse/neglect from administrative staff on 08/26/11. One facility employee was on medical leave and will be educated prior to being allowed to work. The attendance rosters for the training were compared to the facility's time reports for active working employees and confirmed all employees had received education in abuse/neglect and had received a copy of the facility policy/procedure. The facility's documentation included evidence of each staff member having successfully passed a quiz concerning the information given in the abuse/neglect training. Staff interviews were conducted on 08/31/11 from 3:40 PM to 4:30 PM, and on 09/01/11 at 11:42 AM, with LPN #11, LPN #12, KMA #2, SRNA #14, SRNA #15, Housekeeper #1, and Housekeeper #2 related to the facility's abuse/neglect training. Staff verified the receipt of training and each had received a copy of the facility's revised policy/procedure.</p> <p>A review of the facility's training records revealed evidence the facility's Department Heads had received training in abuse/neglect and reporting. The Checklist File was included in the facility's documentation.</p> <p>A review of the facility's 24-hour Nursing Report,</p>	F 226		

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F 226	Continued From page 51 used as the monitoring tool for signs of abuse, revealed documentation of daily monitoring of residents including any changes in condition or new orders. Interview with the Assistant Administrator on 09/01/11 at 11:10 AM, revealed the 24-hour Nursing Report was reviewed on a daily basis and any concerns were investigated. The Assistant Administrator stated the results of the monitoring would be part of the facility's Quality Assurance process. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systematic changes and quality assurance activities.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy/procedures it was determined the facility failed to ensure the wheelchair for one (1) of twenty-two (22) sampled residents (Resident #4) was kept clean and sanitary. The resident's wheelchair remained soiled for two days during the survey. The findings include:	F 253		

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F 253	<p>Continued From page 52</p> <p>Review of the facility policy/procedure "Wheelchair Cleaning Procedure" (no date given) revealed staff was required to remove soil, food, waste, and odors from wheelchairs. The policy/procedure did not designate who was responsible for cleaning resident wheelchairs or how frequently the wheelchairs were to be cleaned.</p> <p>Observations of Resident #4 on 08/29/11 at 3:30 PM, 4:00 PM, 5:26 PM, and 6:02 PM and on 08/30/11 at 8:30 AM and 9:20 AM, revealed the resident utilized a wheelchair for out of room activities. The wheelchair was fitted with a pressure relieving cushion. The cushion on the wheelchair had debris and food particles on the right side of the cushion and on the seat of the wheelchair. The outer right side of the wheelchair above the wheel had a light brown-colored substance in a smear pattern approximately six inches in width and three inches in height starting below the arm rest.</p> <p>Review of the comprehensive assessment, dated as completed 10/15/10, for Resident #4 revealed the resident had been assessed by the facility to be severely cognitively impaired and had moderate visual impairment. An interview with Resident #4 could not be conducted.</p> <p>Interview on 08/30/11 at 9:20 AM, with State Registered Nursing Assistant (SRNA) #4 revealed residents' wheelchairs were cleaned at least one time each week and more often if the wheelchair had "stuff" on it. SRNA #4 was unaware when the wheelchair was last cleaned but stated it should have been cleaned when the</p>	F 253		

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F 253	Continued From page 53 resident was placed in bed.	F 253			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure care was provided in accordance with the plan of care for one (1) of twenty-two (22) sampled residents. A review of the plan of care developed for Resident #8 revealed staff was to utilize a bed alarm on the resident's bed to alert staff if the resident attempted to rise from the bed unassisted. However, an observation conducted on 08/29/11, revealed the resident's bed did not have a bed alarm in place. The findings include: An interview conducted with the Acting Director of Nursing (DON) on 08/31/11 at 10:00 AM, revealed the facility did not have a specific policy related to staff compliance with each resident's plan of care. A review of the medical record revealed Resident #8 was diagnosed with Alzheimer's, Psychosis, and Osteoarthritis. A review of the most recent quarterly Minimum Data Set (MDS) assessment for Resident #8 revealed the resident's cognition was severely impaired and the resident was	F 282			

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F 282	Continued From page 54 assessed to be a fall risk. Observation of Resident #8 conducted on 8/29/11 at 4:25 PM, revealed the resident was lying in a low bed and a personal bed alarm was not in place. An interview conducted with Kentucky Medication Aide (KMA) #1 on 8/29/11 at 4:35 PM, revealed the KMA had transferred the resident to bed from a wheelchair and forgot to transfer the alarm from the chair to the bed and attach the alarm to the resident.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined the facility failed to ensure two (2) of twenty-two (22) sampled residents at risk for pressure sores received necessary treatment and services to promote healing and prevent the development of new sores. Staff failed to identify a pressure sore on Resident #8's skin. In addition skin assessments/body checks were not completed	F 314		

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F 314	<p>Continued From page 55 according to facility policy for Residents #8 and #20.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Prevention and Care of Decubitus" (revised 08/07/03) revealed breaks in residents' skin were required to be reported at once.</p> <p>A review of the facility policies titled "Treatment of Skin Integrity Problems" and the "Body Check Policy" (undated) revealed all residents were to receive appropriate interventions to prevent and treat skin integrity problems. Additional review revealed a weekly body check was required to be done on all residents and documentation of the findings was to be made in the nursing notes.</p> <p>1. Record review revealed facility staff conducted a Comprehensive Minimum Data Set (MDS) assessment and Care Area Assessment dated 05/06/11 for Resident #8 and the resident was assessed to be at increased risk for pressure ulcers due to functional declines and incontinence. Care plan interventions revealed staff was to assess the resident's skin on a weekly basis. Continued record review revealed the most recent skin assessment conducted for Resident #8 was on 08/07/11, and the resident's skin was noted to be warm, dry, and intact with redness to buttocks. Record review revealed another skin assessment was not conducted until 08/23/11, 16 days later when requested by the surveyor.</p> <p>Observation of Resident #8's skin conducted on 08/23/11 at 3:20 PM, revealed the resident had a</p>	F 314		

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F 314	<p>Continued From page 56</p> <p>0.3 by 0.4 centimeter open area to the left buttocks.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #13 on 08/23/11 at 3:20 PM, revealed the LPN was assigned to provide care for Resident #8, was not aware of the open area on resident #8's buttocks, and was not aware why Resident #8's skin had not been assessed weekly since 08/07/11.</p> <p>An interview with SRNA #15 conducted on 8/30/11 at 11:00 AM, revealed the SRNA provided care for Resident #8 on 08/23/11, and had not observed the open area. The SRNA stated staff was required to report any open areas to the nurse immediately for assessment and treatment. In addition the SRNA stated she must have missed the open area when she provided care to Resident #8.</p> <p>2. Review of the facility policy/procedure "Preventative Skin Care Program" (no effective date) revealed residents would be provided with a skin assessment at admission and a weekly skin assessment would be completed throughout the resident's admission. The policy stated the skin assessment would be documented in the patient's record by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).</p> <p>Observations on 08/31/11 at 10:00 AM, revealed the resident was in bed positioned on the left side. Observations by the surveyor on 08/31/11 at 10:00 AM, of a skin assessment of Resident #20 conducted by facility staff revealed no open areas or nonblanchable reddened areas.</p>	F 314			

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F 314	<p>Continued From page 57</p> <p>Review of the medical record of Resident #20 revealed the resident was admitted to the facility on 08/06/09, with diagnoses that included Alzheimer's dementia, Depressive Mental Disorder, Alcohol Abuse, and Hypertension. Review of the annual comprehensive assessment for Resident #20 with an assessment completion date of 08/04/11 revealed the facility assessed the resident to be at risk for the development of pressure ulcers. The resident was assessed to require a pressure reducing device for the bed and applications of ointments and medications to the skin.</p> <p>Review of the nursing notes for Resident #20 from 05/29/11 to 08/30/11, revealed a skin assessment was performed on 06/01/11, and the resident was observed to have reddened areas to the buttocks. Further review of the nursing notes revealed staff had not conducted a skin assessment for Resident #20 from 06/01/11 until 07/27/11, a timeframe of approximately 8 weeks. The nursing notes dated 07/27/11, documented no new reddened or open areas were observed. A skin assessment was completed on 08/03/11, with no open or reddened areas identified. There was no documentation of skin assessments until 08/22/11, when staff discovered an unstageable pressure ulcer to the resident's left buttocks while bathing the resident. A skin assessment was documented as completed on 08/24/11, that documented a treatment had been applied to the resident's buttocks.</p> <p>Interview on 08/31/11 at 10:50 AM, with Licensed Practical Nurse (LPN) #11 revealed Resident #20 was on the facility's schedule to receive weekly skin assessments on the 3-11 PM shift each</p>	F 314			

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F 314	Continued From page 58 Wednesday. According to LPN #11, the treatment nurse on each shift was responsible for conducting skin assessments. LPN #11 stated she was unaware if anyone monitored to ensure skin assessments were conducted. LPN #11 stated she was made aware of the resident's skin breakdown on 08/22/11, by the SRNAs preparing to bathe the resident. The LPN stated she observed the area and it was not stageable because it was covered with a "scab." The LPN stated the "scab" fell off a few days later and LPN #11 did not know why the skin assessments for Resident #20 were not completed as required.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on environmental observation, interview, and a review of the facility maintenance policy it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible. Hot water temperatures in resident rooms and baths on the C Hall were 120 to 130 degrees Fahrenheit on	F 323		

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F 323	<p>Continued From page 59</p> <p>08/30/11, and electrical power cords and television cables were not secured in resident rooms and presented an entanglement hazard for residents.</p> <p>The findings include:</p> <p>1. A review of the facility policy and procedure for water temperatures (undated) revealed water temperatures were checked three times a week, at random. Additional review of the policy revealed any time the water temperature was not 100 to 110 degrees Maintenance would immediately adjust the hot water source to correct the water temperature.</p> <p>Observations of water temperatures conducted on 08/30/11 at 9:00 AM, revealed the hot water temperature in resident room 104 was 126 degrees Fahrenheit at the residents' sink and 130 degrees Fahrenheit in the residents' bath.</p> <p>Observation on 08/30/11 at 9:15 AM, of the hot water heater for the C Hall revealed the water temperature thermostat was set at 120 degrees and a mixing valve was present on the hot water outlet line. Further observations revealed the outlet line did not have a thermometer to monitor the hot water temperature.</p> <p>An interview conducted with the Maintenance Director on 08/30/11 at 9:15 AM, revealed the facility water thermometer was broken and had not been replaced. The Maintenance Director adjusted the hot water temperature to 112 degrees but did not adjust the mixing valve.</p> <p>Observations of the water temperatures in C Hall</p>	F 323			

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F-323	<p>Continued From page 60</p> <p>rooms 101-105 conducted on 08/30/11 at 10:15 AM, after the water heater had been adjusted, revealed the hot water temperatures were 120 degrees Fahrenheit.</p> <p>On 08/30/11 at 10:30 AM, the Facility Co-Owner adjusted the mixing valve, and the water temperature decreased to 80 degrees Fahrenheit.</p> <p>An interview conducted with the Co-Owner on 08/30/11 at 10:30 AM, revealed Maintenance had made repairs to the water heater piping on 08/29/11, and had accidentally turned the mixing valve.</p> <p>A review of the facility water temperature log for the month of 08/11 revealed that the water temperature for the C Hall was checked on 08/29/11. However there was no evidence the water temperatures were checked after repairs were made to the water heater piping on 08/29/11.</p> <p>2. A review of the facility Maintenance Policy (undated) revealed maintenance requests were made by staff and documented in maintenance binders at each nurses' station and the binders were checked by maintenance staff two times daily.</p> <p>Observations conducted during an environmental tour with the Maintenance Director on 08/31/11 at 8:55 AM, revealed television cables with protruding sharp wires hanging from the ceiling at eye level near the resident sinks in resident rooms 35 and 37. In addition, loose electrical cords were observed hanging from resident</p>	F 323		

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F 323	Continued From page 61 televisions in rooms 11, 13, 19, 103, and 104. An interview conducted with the Maintenance Director on 08/31/11 at 8:55 AM, revealed that he made rounds and checked the maintenance logs daily and had not noticed the television cords and cables hanging down. Additional interview revealed the Maintenance Director had not received any work orders to repair or reroute the cables.	F 323		
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy/procedures it was determined the facility failed to ensure three (3) of three (3) dietary staff members kept their hair contained during meal preparation. The findings include: Review of the facility policy/procedure related to dietary sanitation revealed staff was required to keep hair covered/contained during meal preparation.	F 371		

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F 371	<p>Continued From page 62</p> <p>Observation of the evening meal preparation was conducted on 08/29/11 at 4:32 PM. The Dietary Manager was observed wearing a hair net to cover her hair. The hair net did not cover the back of the Dietary Manager's hair from the level of the ears down to the neck. Dietary Aide (DA) #1 was preparing containers of coffee for tray line distribution. DA #1 had a hair covering in place; however, stands of hair approximately three inches in length were hanging onto the DA's back outside of the hair covering. Continued observations revealed DA #2 went into the walk-in cooler, obtained chilled foods, and returned to tray line preparation. DA #2 had no head covering on.</p> <p>Interview with DA #2 on 08/29/11 at 4:35 PM, revealed staff was required to have their hair covered in the Dietary Department. DA #2 confirmed she had entered the food cooler without a hair covering and stated the covering "must have fallen off."</p> <p>Interview with the Dietary Manager on 08/29/11 at 5:04 PM, revealed staff in the Dietary Department should have their hair fully contained, especially during food preparation. The Dietary Manager was unaware staff was not covering their hair as required.</p>	F 371		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	F 441		

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F 441	<p>Continued From page 63</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to ensure effective infection control measures</p>	F 441		

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F 441	<p>Continued From page 64</p> <p>were utilized by facility staff to prevent the spread of infection. Observation of incontinence care provided to Resident #9 on 08/29/11, revealed staff failed to wash their hands and/or change gloves when applicable and failed to provide a sanitary environment by placing soiled linens on the resident's bed rail and floor. Additionally, the facility failed to ensure that glucometer machines were cleansed/disinfected in accordance with manufacturer's recommendations.</p> <p>The findings include:</p> <p>1. A review of the facility's Infection Control policy (undated) and Nursing Services policy (undated) revealed the facility would maintain an infection control program designed to provide a safe and sanitary environment and prevent the development of disease and infection. According to the policies the Director of Nursing (DON) would enforce policies and procedures, orient, instruct, and supervise personnel. During employee orientation instruction would be given which emphasized handwashing techniques and handling of linen and contaminated materials. The policies further detailed that monitoring of employee performance in regards to infection control would be maintained with additional instruction given as needed.</p> <p>An observation of State Registered Nurse Aides (SRNAs) #12 and #13 as they provided incontinence care to Resident #9 was conducted on 08/29/11 from 1:00 PM until 1:55 PM. During the observation Resident #9 was observed to be soiled with a large amount of loose liquid stool. Observation revealed the heel flotation device utilized by Resident #9 was soiled with stool and</p>	F 441		

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F 441	<p>Continued From page 65</p> <p>SRNA #12 was observed to wipe the heel flotation device with a damp washcloth that had been used to clean Resident #9's buttock area, and then place the heel flotation device on the floor. The SRNAs were observed to place linen on the resident's bed which was soiled with the liquid stool, and failed to clean the air mattress that Resident #9 was lying on, despite the mattress being visibly soiled and wet from the liquid stool. SRNA #13 was observed to place the stool-saturated washcloths on Resident #9's bed rail. SRNA #13 was also observed to remove her soiled gloves and exit the room (having to open the door by utilizing the door knob) and failed to wash her hands or use hand sanitizer prior to leaving the room. SRNA #13 then returned to the room with clean washcloths which the SRNA stated she obtained from the clean linen cart. The soiled linens that contained the large amount of pooled loose liquid stool were placed on the floor beside Resident #9's bed, and SRNA #12 was observed to walk on the soiled linens. After completion of incontinence care for Resident #9, SRNA #12 was observed to retrieve the heel flotation device from the floor and place it in the bed under Resident #9's ankles. SRNA #12 was observed to then move the resident's urinary catheter from one side of the bed to the other and adjust the tubing, with the same soiled gloves utilized throughout the incontinence care observation.</p> <p>Interviews were conducted on 08/29/11 at 2:20 PM, with SRNA #13, and at 2:25 PM, with SRNA #12. Both SRNAs stated they recently became SRNAs (SRNA #12 on 04/08/11, and SRNA #13 on 07/08/11) and had not received training at the facility regarding infection control procedures</p>	F 441			

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F 441	<p>Continued From page 66</p> <p>related to incontinence care to residents. The SRNAs stated they had completed incontinence care while attending SRNA classes, but had never been "watched" or evaluated since being employed by the facility to ensure they were providing care correctly. SRNA #13 stated she placed the soiled washcloths on Resident #9's bed rails "because I couldn't reach the bedside table" stating the bedside table would have been the appropriate place to place the soiled cloths, and stated she "forgot" to wash her hands after she removed the soiled gloves prior to obtaining clean washcloths. Both SRNAs reportedly "didn't think" about cleaning Resident #9's air mattress even though it was visibly wet from the stool. SRNA #12 stated she was unaware that the soiled linens or the adaptive equipment (heel floatation device) should not have been placed on the floor, and did not think the adaptive equipment required additional cleansing.</p> <p>An interview conducted with LPN #10 on 08/29/11 at 2:36 PM, revealed she had "noticed some concerns" during the observation of incontinence care for Resident #9, such as the SRNAs not washing their hands when indicated and placing soiled linens on the floor. However, LPN #10 stated she "mainly passed meds" at the facility and was unsure if she should correct or instruct the SRNAs on appropriate infection control measures, and indicated that would have been the responsibility of the charge nurse. However, LPN #10 stated she had failed to notify the charge nurse of her "concerns" regarding the observation of incontinence care for Resident #9.</p> <p>Interviews were conducted on 08/31/11 at 11:30 AM, with the Human Resources Director (HRD)</p>	F 441		

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F 441	<p>Continued From page 67</p> <p>and at 1:20 PM, with the MDS Coordinator. The HRD stated that SRNAs were placed with other SRNAs (preceptors) to work "on the floor" for two weeks after being hired by the facility. The HRD stated the SRNA's "preceptor" would be responsible to train the newly hired SRNA in each area on the Orientation Checklist, which included including infection control standard precautions. However, the HRD stated the facility did not require the newly hired SRNAs to demonstrate any competency evaluation after completion of the two week orientation, and did not have a system in place to evaluate or to ensure the employee responsible for training a new employee was competent in the performance listed on the checklist. Although the Minimum Data Set (MDS) Coordinator had signed the Orientation Checklists (undated) for SRNAs #12 and #13, the MDS Coordinator stated her signature was only to verify that each item had a check mark by it, not that the SRNA was competent in or safe to perform the skill.</p> <p>An interview on 08/31/11 at 9:00 AM and 10:00 AM, with Registered Nurse (RN) #1/acting DON revealed the facility did not have a system in place to periodically evaluate or ensure staff was competent to provide patient care, or used effective infection control measures.</p> <p>2. Review of the facility's policy/procedure "Cleaning and Sanitizing the Glucometer" (no effective date) revealed staff was required to wipe the glucometer before each use with an alcohol prep or a sanitizing wipe and allow the surface to air dry.</p> <p>Review of the manufacturer's directions for use</p>	F 441			

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F 441	Continued From page 68 for the Sani-Wipe (brand name) disinfectant utilized by the facility to clean the glucometer revealed in order to disinfect a surface the wipe was to be used on the entire surface. According to the manufacturer, for the disinfectant to be effective the surface of the glucometer should be visibly wet for two minutes to ensure adequate disinfection. Observations on 08/31/11 at 11:05 AM, revealed Licensed Practical Nurse (LPN) #10 obtained a blood specimen for glucose testing from an unsampled resident (Resident #A). After use of the glucometer, LPN #10 obtained a Sani-Wipe, wiped the surface of the glucometer, and placed the device back into the storage area for the next use. The LPN failed to ensure the surface of the device was kept visibly wet for two minutes as directed by the manufacturer. Interview with LPN #10 on 08/31/11 at 11:10 AM, revealed the LPN would wipe down the glucometer with the Sani-Wipe. LPN #10 stated she was unaware of the manufacturer's directions for use of the Sani-Wipe. According to LPN #10, she had been told to just wipe the glucometer down with the wipe. During an interview on 08/31/11 at 11:15 AM, with LPN #11 it was revealed the LPN was unaware of the manufacturer's directions for use of the Sani-Wipe. LPN #11 stated staff used the wipe as though it was an alcohol swab and did not wipe for any amount of time.	F 441		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that	F 490		

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F 490	<p>Continued From page 69</p> <p>enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility investigation review, and facility policy review, it was determined the facility failed to be effectively/efficiently administered in a manner that maintained the highest physical well-being for two (2) of twenty-two (22) sampled residents (Residents #1 and #2). The facility failed to have an effective system in place to ensure facility policies/procedures related to abuse/neglect prevention were implemented.</p> <p>A review of documentation and interviews conducted revealed during the months from 07/11 until 08/11 facility staff became aware that SRNA #8 had exhibited abusive behavior toward two of seventeen sampled residents (Residents #1 and #2). The facility's Administration failed to ensure staff immediately reported all allegations of abuse to administrative staff and appropriate state agencies. In addition, the Administration failed to ensure residents were protected from abuse during the facility's investigation by allowing the alleged perpetrator to continue to provide direct resident care and failed to ensure a thorough investigation was conducted of all allegations. (Refer to F223, F225, and F226.)</p> <p>The Administrator's failure to ensure facility policies/procedures related to abuse/neglect</p>	F 490		

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F 490	<p>Continued From page 70</p> <p>prevention were implemented caused, or is likely to cause, serious injury, harm, impairment, or death to residents in the facility, to include Residents #1 and #2. Immediate Jeopardy and Substandard Quality of Care (SQC) was determined to exist on 07/19/11.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/31/11, which alleged removal of Immediate Jeopardy on 08/31/11. The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Abuse Policy (revised 09/06/00) revealed, "In the event of any evidence to cause to believe that a resident has suffered any abuse; the employee, visitor or family member are requested to report any/all allegations, suspicion, or incidents to the administration of the facility, i.e. charge nurses, supervisors, DON, SSD, or administrator." The policy stated, "Upon report of any allegations or violations, the administration will thoroughly investigate the situation. Any employee suspected of abuse, neglect, or disregard for resident welfare will be suspended from direct resident care while the investigation is in progress." The review revealed the investigation would include, but not be limited to, the following: names of all individuals involved, witnesses that actually viewed the incident, the resident's/family's statement concerning the incident, when and where the incident occurred,</p>	F 490		

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F 490	<p>Continued From page 71</p> <p>and any evidence of injury or abuse present on the resident's body or in the resident's actions. The policy revealed, "The results of the investigation shall be documented and place in the investigation file." The policy also revealed, "After knowledge of an allegation of abuse, the administrator, director of nursing or social service director shall report it to Adult Protective Services and the Cabinet for Human Resources immediately. The results of all investigations will be reported to the same agencies within five (5) working days of the incident."</p> <p>1. An interview with Certified Medication Aide (CMA) #1 on 08/22/11 at 2:45 PM, revealed on 07/20/11, Certified Medication Aide (CMA) #1 reported to the Director of Nursing (DON) that State Registered Nurse Aide (SRNA) #8 had been physically, mentally, and verbally rough with Resident #2 and Resident #8. Interviews with the DON on 08/22/11 at 6:30 PM, the Assistant Administrator on 08/22/11 at 7:00 PM, and the Assistant Administrator and Administrator on 08/25/11 at 6:05 PM, revealed they were unaware of this allegation. Therefore, the facility had no documentation that administrative staff investigated or notified the appropriate state agencies regarding this allegation or protected the residents from further potential abuse.</p> <p>2. On 07/21/11, Resident #2 reported SRNA #8 had physically abused Resident #2. A review of the facility's undated investigation revealed the Administrator was notified of the allegation at approximately 8:20 AM on 07/21/11, and instructed the DON "not to report as this didn't happen." The DON's statement revealed at 12:10 PM on 07/21/11, the DON reported the</p>	F 490			

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F 490	<p>Continued From page 72</p> <p>allegation again to the Administrator who stated, "Quit worrying about this;" the resident is "crazy." Further review of the investigation revealed SRNA #8 continued to provide direct care to residents from the time the allegation was reported on 07/21/11, until 07/25/11 at 3:00 PM, when the SRNA was suspended for two days. A review of the investigation revealed the facility had failed to determine a conclusion of their investigative findings and the appropriate state agencies had not been notified of the allegation. An interview with the DON on 08/22/11 at 6:30 PM, revealed staff reported Resident #2's allegation on 07/21/11; however, SRNA #8 continued to provide direct care to residents on 07/22/11, 07/23/11, and 07/24/11. The DON confirmed she did not conduct a conclusion to the facility's investigation and no one notified the appropriate state agencies of the allegations. An interview with the Administrator on 08/25/11 at 6:05 PM, revealed he was informed of Resident #2's allegation on 07/21/11, and, due to the resident being "delusional," the allegation was not reported to the appropriate state agencies.</p> <p>3. An interview with SRNA #2 on 08/23/11 at 10:10 AM, revealed on 08/10/11, SRNA #2 reported to her supervisor (Restorative Aide #2) she had witnessed SRNA #8 lie on the bed and "spoon" Resident #1, however, the Restorative Aide (RA) did not report the allegation to administrative staff (charge nurse, supervisor, DON, SSD, or Administrator) as required. Interview with Licensed Practical Nurse (LPN) #6 on 08/24/11 at 5:15 PM, revealed she was informed at approximately 6:45 AM on 08/11/11, that SRNA #8 was in the bed with a female resident. LPN #6 waited 26 hours before she</p>	F 490		

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F 490	Continued From page 73 reported the allegation to the Human Resources Director (HRD). Interview with the HRD on 08/22/11 at 4:45 PM, revealed she reported the allegation to the Assistant Administrator on 08/12/11 at approximately 10:30 AM, and the allegation was reported to the Administrator. At that time, based on interviews and record review, SRNA #8's employment was terminated and he was escorted off the premises. However, according to an interview with the Assistant Administrator on 08/24/11 at 7:50 PM, she did not notify the Office of Inspector General (OIG) because she was unaware of the regulation that required reporting of alleged abuse. The facility's undated investigation related to the allegation revealed the Assistant Administrator failed to conduct a thorough investigation of the allegation and failed to notify the appropriate state agencies of the allegation. 4. In addition, based on interviews, SRNA #8 exhibited a history of unacceptable behaviors that facility staff failed to report. Interviews conducted on 08/22/11 at 5:20 PM; with SRNA #1, on 08/23/11 at 2:27 PM, with LPN #3, and on 08/23/11 at 4:25 PM, with LPN #5 revealed staff had witnessed SRNA #8 inappropriately kiss several female residents. SRNA #1 reported SRNA #8's inappropriate behaviors to the charge nurses on numerous occasions and to the HRD. LPN #3 discussed the SRNA's inappropriate behaviors with SRNA #8 and reported his behaviors to the HRD on two occasions. LPN #5 counseled SRNA #8 on the inappropriateness of kissing the residents, in the presence of the HRD. The interview revealed LPN #5 was under the impression the HRD would inform the DON of SRNA #8's inappropriate behaviors. Interviews.	F 490		

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F 490	<p>Continued From page 74</p> <p>with the HRD and the DON on 08/22/11 at 6:30 PM, revealed they were unable to recall if staff had reported SRNA #8's inappropriate behaviors. The facility failed to conduct an investigation and did not notify the appropriate state agencies of the allegations. Interview with the HRD on 08/22/11 at 4:45 PM, revealed in 06/11 she witnessed SRNA #8 inappropriately kiss Resident #4. The interview revealed the HRD had a discussion with SRNA #8 about his inappropriate behaviors and had reported her observations and discussion with SRNA #8 to the DON the following day. Interview with the DON on 08/22/11 at 6:30 PM, revealed she could not recall that the HRD had reported SRNA #8's inappropriate behaviors to her. There was no evidence the facility investigated or reported the allegations to the appropriate state agencies. In addition, there was no evidence the facility protected the residents from further potential abuse.</p> <p>--A review of the Allegation of Compliance revealed the following:</p> <p>The facility terminated SRNA #8 on 08/12/11, when administrative staff was made aware of the allegation involving SRNA #8 and Resident #1.</p> <p>The facility initiated an investigation of the allegation involving SRNA #8 and Resident #1. On 08/12/11, the Assistant Administrator and the HRD conducted interviews with all staff members who may have information regarding the allegation.</p> <p>The facility had nursing staff conduct physical examinations of all residents SRNA #8 had</p>	F 490		

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F 490	<p>Continued From page 75</p> <p>provided care to during the time frame of 08/06/11 through 08/12/11, to determine if there were any signs/symptoms of abuse.</p> <p>On 08/30/11, RN #1 and LPN #1 conducted interviews with the alert and oriented residents about possible abuse issues.</p> <p>On 08/30/11, the Assistant Administrator and the Co-Owner conducted interviews with 13 family members/visitors, which included family members of non-oriented residents to determine if there were any signs/symptoms of abuse or any complaints.</p> <p>On 08/25/11, Legal Counsel was contacted concerning the Immediate Jeopardy in abuse investigation, protection, and reporting. Legal Counsel and Administration immediately began review and revisions to the facility's Abuse policy. The final revisions were completed on 08/30/11. Policy changes involved the supervision of staff concerning the supervisory staff's duty to monitor and evaluate the staff that may have greater potential for abuse. The policy instructs staff to advise supervisors of problems dealing with stress. Other policy changes involved the screening procedure to include a screening process for administration to use upon hire, in addition to the criminal record checks, abuse registry screens, license/certification verification, and reference checks. The investigation section of the policy was also strengthened to ensure investigations are initiated upon reports of suspected abuse as defined in the Investigation Protocol. The protection section of the policy was revised to state that if a report of abuse is made that involves an employee, that employee will be</p>	F 490			

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F 490	<p>Continued From page 76</p> <p>reassigned from resident care or suspended during the investigation.</p> <p>On 08/25/11 and 08/30/11, the Assistant Administrator and the Administrator received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by Legal Counsel.</p> <p>On 08/26/11, the Education Assistant, the DON, and the Co-Owner received training concerning abuse prevention, abuse protection, abuse investigation, and abuse reporting by the Assistant Administrator.</p> <p>On 08/26/11, training was conducted for all 150 staff members including non-clinical staff during each shift (10 AM, 2 PM, 4 PM, and 11 PM) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner. Upon completion of the training all staff was given a written quiz to verify the staff's comprehension of the material. The facility currently has one staff person on medical leave that will receive this training upon returning to work. All new staff will receive this training upon date of hire. Continued abuse training will be conducted on a bi-annual basis for all staff.</p> <p>On 08/26/11, supervisory staff received specific training on recognizing situations that may indicate stress on staff because staff working under excessive emotional stress were more likely to be impatient with a greater likelihood of committing abuse. The training was conducted by the Education Assistant, the Assistant</p>	F 490			

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F 490	<p>Continued From page 77</p> <p>Administrator, and the Co-Owner.</p> <p>On 08/26/11 and 08/30/11, all Department Heads received specific training about the new policies/procedures emphasizing that potential abuse must be reported to both the OIG and DCBS with the final results of the investigation communicated within five working days. Upon completion of the training all Department Heads were given a written quiz to verify the staff's comprehension of the material. The training was conducted by the Education Assistant, the Assistant Administrator, and the Co-Owner.</p> <p>On 08/26/11, an Abuse Response Checklist File was developed and distributed to the Department Heads to assist the staff in following the correct procedures. The Checklist File consists of the Self Reporting Form published by the OIG.</p> <p>The DON will review compliance with training requirements and will report any and all findings to the Quality Assurance committee on a quarterly basis, which will monitor the facility's compliance.</p> <p>The treatment nurse will monitor residents on a daily basis for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse. The charge nurse is required to report the findings to the DON, who will immediately report to the Assistant Administrator.</p> <p>The Abuse Response Checklist File for the Department Heads will walk the individual through the steps that should be taken when abuse is</p>	F 490		

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F 490	<p>Continued From page 78</p> <p>suspected or reported. All reports of suspected abuse will be immediately reported to the charge nurse. The charge nurse will immediately report the suspected abuse to the DON, who will document the allegation on the 24-hour nurses' report.</p> <p>The DON and the Assistant Administrator will review the 24-hour nurses' report on a daily basis and will report any alleged abuse to the Administrator and the appropriate state agencies. Upon report of any alleged violations the Administration will thoroughly investigate the allegation.</p> <p>The Administrator and the Assistant Administrator will monitor any suspected or actual abuse according to facility policy to ensure the resident is protected by suspending or reassigning the alleged perpetrator, if an employee, during the investigation process. The Administrator and the Assistant Administrator will also monitor that a conclusion to the investigation is completed and that reporting has been made to the appropriate agencies.</p> <p>The Quality Assurance Committee will receive all reports of suspected or actual abuse and will monitor to ensure compliance with facility policy and regulation.</p> <p>—The surveyors validated the corrective actions taken by the facility as follows:</p> <p>A review of the Employee Master Change Sheet revealed SRNA #8 was terminated effective 08/12/11, by the Human Resources Director.</p>	F 490		
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F 490	<p>Continued From page 79</p> <p>A review was conducted of the facility's investigation. The investigation was initiated on 08/12/11, when administrative staff received the report of the abuse and SRNA #8 was immediately removed from the facility and escorted off the premises by local Police.</p> <p>A review of the physical examinations of residents cared for by SRNA #8 on 08/06/11 through 08/12/11, was conducted. Skin assessments for eight residents under the care of SRNA #8 had been conducted and documented by LPN #3 and each resident was questioned by LPN #8. Interview with LPN #3 on 09/01/11, revealed the LPN had conducted the skin assessments at the request of the Human Resources Director after SRNA #8 had been escorted from the facility. According to LPN #3, no injuries or skin changes had been noted. Skin assessments conducted during the survey revealed no injuries of unknown source. Interviews were conducted with family members of Residents #1 and #4. The family members denied any injuries or mistreatment of the residents.</p> <p>A review of the documentation of interviews with alert/oriented residents and family members conducted by RN #1 revealed no identified problems from the interviews. A resident group interview was conducted by surveyors on 08/30/11 at 10:00 AM, and no reports of abuse/neglect were reported.</p> <p>A review of the facility's revised policy/procedure for abuse/neglect revealed the facility had addressed all requirements for the policy/procedure. The revised policy/procedure</p>	F 490		

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F 490	<p>Continued From page 80</p> <p>included education to address staff behaviors that would indicate a potential for abuse. The investigation section of the policy/procedure addressed the need to immediately notify state agencies and reporting requirements for suspected abuse/neglect of residents.</p> <p>Interview on 09/01/11 at 10:35 AM, with the facility's Legal Counsel revealed the Legal Counsel had educated the Administrator and Assistant Administrator on abuse/neglect and the regulatory requirements for Long Term Care Facilities from 08/12/11 through 08/30/11. According to Legal Counsel, the Administrator and Assistant Administrator were educated on reporting requirements of suspected abuse and what the definitions for abuse/neglect/misappropriation were. Review of the revised facility policy/procedure revealed the policy met regulatory requirements.</p> <p>A review of the facility's training records revealed evidence that all employees of the facility except for one had received training on abuse/neglect from administrative staff on 08/26/11. One facility employee was on medical leave and will be educated prior to being allowed to work. The attendance rosters for the training were compared to the facility's time reports for active working employees and confirmed all employees had received education in abuse/neglect and had received a copy of the facility policy/procedure. The facility's documentation included evidence of each staff member having successfully passed a quiz concerning the information given in the abuse/neglect training. Staff interviews were conducted on 08/31/11 from 3:40 PM to 4:30 PM, and on 09/01/11 at 11:42 AM, with LPN #11, LPN</p>	F 490		

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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423
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(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 490	<p>Continued From page 81</p> <p>#12, KMA #2, SRNA #14, SRNA #15, Housekeeper #1, and Housekeeper #2 related to the facility's abuse/neglect training. Staff verified the receipt of training and each had received a copy of the facility's revised policy/procedure.</p> <p>A review of the facility's training records revealed evidence the facility's Department Heads had received training in abuse/neglect and reporting. The Checklist File was included in the facility's documentation.</p> <p>A review of the facility's 24-hour Nursing Report, used as the monitoring tool for signs of abuse, revealed documentation of daily monitoring of residents including any changes in condition or new orders. Interview with the Assistant Administrator on 09/01/11 at 11:10 AM, revealed the 24-hour Nursing Report was reviewed on a daily basis and any concerns investigated. The Assistant Administrator stated the results of the monitoring would be part of the facility's Quality Assurance process.</p> <p>The State Agency determined the Immediate Jeopardy was removed on 08/31/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systematic changes and quality assurance activities.</p>	F 490		

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

Please accept the following addendum to the Plan of Corrections filed with the Cabinet for Health and Family Services on or about September 26, 2011. This Addendum is meant to address the issues identified in the October 12, 2011 letter and to supplement the September 26, 2011 Plan of Corrections.

In addition, please find attached as Appendix A the Credible Allegation of Compliance that was filed on 8/31/11, which resulted in the removal of immediate jeopardy. As such, please accept this as additional proof of compliance.

It is the policy of Charleston Health Care Center ("Charleston") for its residents to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.

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, alleged perpetrator, was terminated as of August 12, 2011 before 11 AM when the matter was brought to the attention of Human Resources Director and communicated to the Administrator. Assistant Administrator was instructed by to terminate the employee. The employee was terminated within the hour.

Pursuant to the direction of the Administrator, immediate investigation of events began on the evening of August 12th, 2011 as soon as Charleston terminated (alleged perpetrator) employment as directed. Nursing staff conducted physical examinations of residents in the care of for the week August 6th 2011 and including up to August 12th, 2011 to determine if any possible abuse had occurred.

, Assistant Administrator and , HR Coordinator, also conducted interviews on the evening of August 12th 2011 with all staff members who may have had information regarding this allegation. The investigation of possible abuse of residents continued as interviews of family members and alert and oriented residents were conducted on August 30, 2011. Resident interviews were conducted by clinical staff that included LPN and , RN who specifically inquired of residents about possible abuse. Family and visitor interviews (13), which included family members on non-oriented patients, were conducted by , Assistant Administrator and Co-Owner on the afternoon of August 30, 2011 to determine if there were any signs of abuse, if patients felt they were treated well and asked if they had any complaints. No complaints were noted out of the 13 interviews. A

timeline of interviews with summaries of events was prepared by [redacted] Assistant Administrator and reported to the Administrator

Pursuant to the direction of the Administrator, commencing on Thursday, August 25th, 2011 and thru August 30th, 2011 Facility policies related to the prevention, investigation and reporting of abuse were reviewed and revised. Legal counsel was contacted on August 25, 2011 concerning revision of the policies and other matters.

Once Charleston became aware of the situation, the Administrator and the Assistant Administrator determined that changes in policy and additional training of staff was necessary. On Friday, August 26th, 2011 training was conducted for all staff including non-clinical staff during each shift (10am, 2pm, 4pm, and 11pm) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by key employees of the Facility including [redacted] Marketing/PR Coordinator and Education Assistant; [redacted] Assistant Administrator; and [redacted] Co-Owner. Training session was overseen by the Administrator, [redacted] Both [redacted] and [redacted] received training from [redacted] concerning abuse prevention, abuse investigation and abuse reporting. The Director of Nursing, [redacted] RN was then trained by [redacted] regarding allegation of abuse, reporting of abuse and investigation process regarding abuse allegations. [redacted] Assistant Administrator and [redacted]

[redacted] Administrator received training concerning abuse prevention, abuse investigation, and abuse reporting by legal counsel, [redacted] commencing August 25, 2011 and continuing through the present. Additional consultation was provided by [redacted] who is also legal counsel concerning the situation with [redacted] the alleged perpetrator commencing August 12, 2011. At the completion of the training for the staff, a written quiz was taken by each staff member to verify the employee's comprehension of the material. This training was given to all 150 current employees. Training concerning abuse prevention, abuse investigation and abuse reporting will be given to any new employees of the Facility upon date of hire. Further, the Facility currently has one employee on medical leave. This employee will receive training concerning abuse prevention, abuse investigation and abuse reporting upon returning from medical leave. The employees successfully completed the quiz and the results were reviewed by [redacted] Administrator.

The Friday August 26th, 2011 training was given to all employees of the Facility even those without direct patient care duties. Charleston believes that any employee that may have contact with a resident and that all employees should be aware of the potential for abuse and should know how to report it in the event it is suspected or observed. As reported above, the training was conducted by key employees of Charleston including [redacted] Marketing/PR Coordinator and Education Assistant [redacted] Assistant Administrator; and [redacted] Co-owner. Both [redacted] and [redacted] received training from [redacted] concerning abuse prevention, abuse investigation and abuse reporting. [redacted] Assistant Administrator and [redacted] Administrator received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel, [redacted] In addition,

please note that Charleston works with legal counsel, _____, on a regular basis regarding regulatory compliance issues.

On Friday, August 26th, 2011 and August 30, 2011 each Department Head was specifically educated about the new policies and procedures emphasizing that potential abuse must be reported to both the Office of Inspector General and Adult Protective Services with the final results of an investigation communicated within five days. New tools have been developed for the use of Department Head staff. Verification of understanding of policies by Department Head staff was conducted by taking a quiz on the information received. The results of the quiz were reviewed by Marlin Sparks, Administrator and _____, Assistant Administrator, on the evening of Friday, August 26th, 2011. On Friday, August 26th, 2011 a checklist file was prepared and distributed to the department heads to assist them in following the correct procedures. Included in the Abuse Response Checklist is the Self-Reporting Form published by the Division of Health Care entitled "Long Term Care Facility-Self-Report Incident Form" along with the instructions. In addition, on the evening of August 30th, 2011 training regarding the emphasis of reporting suspected abuse was conducted by _____, Assistant Administrator, which was overseen and presented under the direction of Marlin Sparks, Administrator. _____ and _____ received training from legal counsel, _____ regarding suspected abuse reporting requirements.

The Abuse Policy-Supervision of Staff related to Abuse Potential was updated and revised concerning a supervisory employee's start to monitor and evaluate employees who may have a greater potential for abuse of a resident. This policy was revised on Thursday, August 25, 2011, immediately upon notification of the immediate jeopardy. This policy also instructs an employee to advise his or her supervisor if he or she is having problems dealing with stress-whether personal or work related. Both supervisors and employees are reminded of the confidential nature of these communications to the extent that resident safety is not compromised. Training about the revised and existing policies related to abuse was conducted by key employees _____ Marketing/PR Coordinator and Education Assistant; _____, Assistant Administrator, and _____ Co-owner, who were approved and overseen by the Administrator, _____ and the Assistant Administrator, _____. Both _____ and _____ received their training from _____ concerning abuse prevention, abuse investigation, and abuse reporting. _____ and _____ received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

The Abuse Policy and Screening Procedure for Potential Employees was amended and approved by _____, Administrator, on the Thursday evening, August 25th 2011, to include a screening process for administration to use when hiring new employees so that the potential for abuse is specifically considered in addition to the criminal record checks, abuse registry screens, license verification, state registration verification and reference checks. In Addition, all revision and amendment to policies were reviewed and approved by _____, Administrator. The training was conducted by key employees of Charleston including _____, Marketing/PR Coordinator and Education Assistant; _____ Assistant Administrator, and _____ Co-owner,

who were overseen by the Administrator, Both and received training from , Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

In addition please note that the Facility works on a continuous basis with Ms. for training on regulatory compliance and is notified by ; for training on regulatory compliance and is notified by of any updates and/or changes to regulatory compliance issues.

The policies related to investigation were also reviewed and strengthened on the Thursday evening, August 25th, 2011 to make sure that investigations are carried out when reports of suspected abuse and abuse have been made as the investigation Protocol makes clear. These policies were reviewed and approved by Administrator.

Continued training will be conducted on a bi-annual basis for all employees of Charleston Health Care Center. This training will include specifics regarding allegation of abuse, reporting of abuse, monitoring for signs of potential abuse and investigation procedures regarding alleged abuse. This training will be overseen and approved by the Administrator, In addition, any new hires will receive the above referenced training upon date of employment. The Director of Nursing will review compliance with training requirements and will report any and all findings to the quality assurance committee on a quarterly basis, which will monitor Facility compliance.

Because all residents may be at risk for harm of ages if it exists changes and improvements were made to policies and procedures concerning abuse prevention, abuse investigation, and abuse reporting, on a system-wide basis and all 150 current staff members were educated about the policies on Friday, August 26th, 2011. The training was conducted by key employees of the Facility including Marketing/PR Coordinator, and Education Assistant; Assistant Administrator; and , Co-owner, who were overseen by , Administrator. Both and received training from concerning abuse prevention, abuse investigation and abuse reporting. and received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Thursday evening, August 25, 2011, these policies include a specific provision that if a report of abuse is made that involves an employee, that employee will be reassigned from resident care to another job or suspended during the investigation. These changes were made to protect resident from retaliation or further acts of abuse.

As of Friday, August 26th, 2011, other policies have been implemented that are aimed at the protection of residents from abuse by employees. This includes training supervisory staff to recognize situation that may indicate stress on employees. Because individuals who are working under excessive emotional stress are more likely to be impatient they have a greater likelihood of committing abuse. The training was conducted by key employees of the Facility including Marketing/PR Coordinator, , Co-owner, and , Assistant Administrator. Both and

received training from _____ Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting. _____ received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Friday August 26th, 2011, Charleston has initiated new procedures to ensure compliance by these important changes to policies and procedures. Education of staff however is vital to insuring that everyone understands their duty to report suspected abuse and to whom it is to be reported. The training will continue on abuse prevention, abuse investigation, and abuse reporting on a bi-annual basis overseen by

Administrator. Also new staff will be thoroughly in-serviced by key employees of the Facility, overseen by Administrator, _____, on the policies and procedures pertaining to abuse, prevention, investigation, and reporting and importance of reporting requirement. In addition, the Facility and its administration believes that by incorporating the duty to be vigilant about employee stressors into the policies for supervisory employees and employees that staff will be more sensitive to situations that make staff more susceptible to acting in an abusive manner.

In addition, residents will be monitored on a daily basis by the treatment nurse for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse, who in turn is required to report the findings to the Director on Nursing, _____ RN, who then reports immediately to _____, Assistant Administrator, and _____ Administrator. _____ Assistant Administrator will then notify any and all appropriate State Agencies.

The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained. As of Thursday evening, August 25th, 2011, the Facility revised relevant policies and as of Friday, August 26th, 2011 has educated staff about those policies. The training was conducted by key employees of the Facility including _____ Marketing/PR Coordinator and Education Assistant, _____ Assistant Administrator; and _____, Co-owner under the supervision and direction of the Administrator _____ Both _____ and _____ received training for _____ concerning abuse prevention abuse investigation and abuse reporting. _____ received training concerning abuse prevention abuse investigation and abuse reporting by legal counsel _____. In addition, by creating the new tool for Department Heads, which walks the individual through the steps that should be taken when abuse is suspected or reported, the Facility is confident that its solution will be sustained. In addition all reports of suspected abuse are to be immediately reported and given to the charge nurse. The charge nurse will then immediately report the suspected abuse to the Director of Nursing and will record the allegation in the 24-hour nurses' report. The Director of Nursing and _____ Assistant Administrator, will review the 24-hour nurses' report on a daily basis and will report any alleged abuse in compliance with any and all regulatory requirement to _____ Administrator, and any and all state agencies necessary. This will insure

that communication of suspected abuse as well as abuse is address and monitored by Facility Administration.

When abuse is suspected or abuse is discovered, the Administrator and the Assistant Administrator shall monitor the situation according to Facility policies to assure that any employee suspected to have perpetrated abuse will be suspended or reassigned from resident care duties until a full investigation has been completed and a determination reached, that all reports have been made, and that the situation has been appropriately documented. Additional monitoring will be carried out by the Quality Assurance Committee that receives all reports of suspected or actual abuse.

Additional in-service training was held on Friday September 16th, 2011, & Tuesday September 20th, 2011 with key department heads and licensed nurses. Training included abuse, abuse reporting, and abuse documentation. Assistant Administrator presented training under the direction of Administrator. Administrator, and Assistant Administrator have received continued education for legal counsel

A book of allegations and log of all abuse, abuse reporting, abuse documentation, abuse investigation if to be kept in the Administrator/Assistant Administrator's office. The book will be used for compliance, quality assurance, and record keeping. This book was started September 2, 2011.

Substantial compliance was met on August 31, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have a finding entered into the state nurse aide registry.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #1 - The plan of correction fails to address corrective actions taken for residents identified in the deficient practice.

Please find attached as Exhibit 1, updated policies addressing abuse allegations.

Resident 1:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action

was taken, the investigation of alleged abuse indicated that Resident #1 did not suffer any abuse or harm either mental or physical. The following specific actions were accomplished for Resident #1:

- Head to toe skin assessment of Resident #1 was completed on 7/22/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse, or harm substantiated for Resident #1.
- Interview with Resident #1 was conducted on 8/12/11.
- Resident #1's family was notified of the alleged abuse and interviewed on 8/13/11. It is interesting that Resident #1's family was supportive of the alleged perpetrator, thought that he worked well with Resident #1, did not confirm any abusive behavior on the part of the employee, and did not note any physical or mental indications of abuse for Resident #1.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #1 based on the report of alleged abuse on 8/15/11 and determined that Resident #1 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.
- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. Initial training of staff was completed by 8/26/11 with additional training in September. In October, policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The

reorganization and restatement of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.

- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.
- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented where allegations of abuse are recorded. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Education of Key Employees that include Administrator, DON, assistant director of nursing, social work director, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11 and again on 9/16/11, and 9/20/11.
- Random interviews of Residents were conducted to identify if any other potential abuse victims existed on 8/30/11.
- Procedures involving the proper recordkeeping for background checks so that only qualified employees with no reported instance of abuse are hired were reviewed. The Facility performs background checks for all staff, not just clinical staff. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures.
- The nursing staff was also educated about their respective duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse, etc. Specific training took place on 8/26/11, 9/16/11 and 9/20/11. Ongoing training is also provided.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.

- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes. Exhibit 3.

Resident 2:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #2 did not suffer any abuse either mental or physical. The following specific actions were accomplished for Resident #2:

- Head to toe skin assessment of Resident #1 was completed on 7/22/11 and on 8/17/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse or harm substantiated for Resident #2. Resident #2 has mental impairments that cause him to make statements that are imagined and without basis. It was determined that Resident #2's statements were not accurate.
- Interview with Resident #2 was conducted on 8/12/11.
- Resident #2's allegations of abuse occurred in July. At the time, staff notified Resident #2's family about his allegations. Later in July the DON personally communicated with Resident #2's family about his allegations. The family as well as Facility staff did not find the allegations to be true as a result of Resident #2's mental status and frequent statements that did not reflect reality. While Resident #2 did name the same CNA his statements were found to be untrue.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #2 based on the report of

alleged abuse on 8/15/11 and determined that Resident #2 had not suffered mental or physical injury.

- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.
- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. The policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional Education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.
- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented to record allegations of abuse. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Key employees include

Administrator, director of nursing, assistant director of nursing, social work, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11.

- Random Interviews of Residents were conducted to identify any other potential abuse victims existed on 8/30/11.
- Proper record check/keeping to identify safe employees upon hire. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures. The nursing staff was also educated about their duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse. etc.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.
- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes.

Criteria # 4 - The plan of correction failed to include specifics/details related to monitoring.

Charleston will monitor its performance on an on-going basis to assure that its Facility Policies and Procedures are implemented in a timely and effective manner. The treatment nurse has been assigned the responsibility of monitoring each shift, (24 hours per day, 7 days per week) for any reports of allegations of abuse. When reported, the treatment nurse is to initiate procedures in a manner consistent with Facility policies and procedures.

- The Facility has implemented a process that includes shared staff responsibility for timely reporting, investigating, addressing, and monitoring allegations of abuse. By assigning the treatment nurse, the

charge nurse, and the DON to report allegations of abuse; effective compliance will be maintained. Date: 9/21/11.

- All Facility staff has been educated about the policies and procedures to be followed when abuse is discovered/reported or allegations of abuse are made. Dates: 8/25/11/ 9/16/11 and 9/20/11.
- All Certified Nursing Assistants ("CNA") have the duty to report any allegations, symptoms, or signs of abuse to charge nurse immediately upon discovery; staff has been extensively educated about this duty. Dates: Dates: 8/25/11/ 9/16/11 and 9/20/11.
- Nursing staff assigned the duties of treatment nurse is required to undertake a specific review of patients and staff for reports of abuse or potential abuse and is to report the same to charge nurse each shift.
- The Charge Nurse has the duty to report allegations of abuse to DON during business hours and if allegations are reported after business hours; the charge nurse is to report the allegations to the Administrator or assistant Administrator when received after business hours.
- The Administrator is to follow up within 48 hours of any report of alleged abuse to determine and verify all policies and procedures regarding alleged abuse were followed and that the investigation has been completed;
- Clinical staff shall assess and identify residents who may have the potential for abusive behavior and this shall be addressed through care planning and monitoring of residents with needs and behaviors that may lead to conflict or neglect.
- Any residents identified as having the potential for abusive behavior through care planning and monitoring will be reported to charge nurse each shift; the charge nurse will then report this information to the Administrator.
- To assure further compliance with monitoring, the Facility has arranged for qualified psychiatrist and other mental health professionals to help the staff manage difficult or aggressive residents.
- Random head to toe examinations, in addition to scheduled skin assessments for residents, will be conducted on a monthly basis by nursing staff. Any signs of abuse will be immediately reported to the charge nurse on duty, which will immediately report the findings to the administration.

- Continuous monitoring will all occur through interviews with visitors, family, volunteers, that will be conducted monthly.
- DON and Assistant Administrator and/or Administrator will meet five times a week specifically to discuss whether any allegations of abuse have been reported or any signs of abuse noted by staff for any resident.
- Daily meeting of the key employees (that include Department Heads, Administrator, Assistance Administrator, MDS Coordinator, DON, Activities Director, Social Services, Dietary, Restorative Nurse, Office Manager and Housekeeping and Laundry) will occur to address concerns and identify problems including any reports of abuse or alleged abuse.
- Monitoring and review of abuse allegations and investigations has been added to Quality Assurance Committee's duties; the Administrator will designate a clinical staff member to monitor and supervise each allegation of abuse that is received prior to the QA meeting to determine whether Facility procedures and policies have been followed in a timely manner.
- Administrator or his delegate has the responsibility to perform and/or supervise the investigation, to make proper and timely reports, and to document satisfactory resolution of abuse allegations. To facilitate timely supervision, a log shall be kept in the Administrator's office that records every allegation of abuse and a tool to determine that Facility policies and procedures have been followed in a timely manner. This book will contain all information IE, incident report, statements, nurses notes, 24-Hour Report, face sheet of resident, MDS, self-report to OIG, fax confirmation, final report, receipt of report to Adult Protective Services along with a log indicating when the action has been taken;
- The Administrator and Assistant Administrator are responsible for reviewing the log book to determine and monitor compliance with regulations and Facility Policies and Procedures. In addition, the Administrator and Assistant Administrator are responsible for making all reports of allegations of abuse and findings, and for completing the investigation within 5 days with the help of key employees. The Administrator shall report the results of all investigations of abuse in timely manner as required by Facility policy and procedure as well as state law.

Criteria #5 – The completion date is prior to the survey exit date.

To address the concerns of the Office of Inspector General, the Facility has revised the Plan of Corrections as previously submitted. Although the Plan of Corrections has been supplemented, the Facility achieved substantial compliance as of 8/31/11. Even though Charleston has taken additional steps including reorganization and restating of abuse policies and procedures on 10/12/11. The

staff was educated on the reorganized and restated policies with written copies of the new policies distributed on 10/13/11. The survey was completed on 9/1/11 and the immediate jeopardy was removed on 8/31/11 even though the original Plan of Corrections has been supplemented, Charleston achieved substantial compliance on 8/31/11.

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alleged perpetrator, was terminated as of August 12, 2011 before 11 AM when the matter was brought to the attention of Human Resources Director and communicated to the Administrator, Assistant Administrator was instructed by to terminate the employee. The employee was terminated within the hour.

Pursuant to the direction of the Administrator, immediate investigation of events began on the evening of August 12th, 2011 as soon as Charleston terminated (alleged perpetrator) employment as directed. Nursing staff conducted physical examinations of residents in the care of for the week August 6th 2011 and including up to August 12th, 2011 to determine if any possible abuse had occurred. Assistant Administrator and HR Coordinator, also conducted interviews on the evening of August 12th 2011 with all staff members who may have had information regarding this allegation. The investigation of possible abuse of residents continued as interviews of family members and alert and oriented residents were conducted on August 30, 2011. Resident interviews were conducted by clinical staff that included LPN and RN who specifically inquired of residents about possible abuse. Family and visitor interviews (13), which included family members on non-oriented patients, were conducted by Assistant Administrator and Co-Owner on the afternoon of August 30, 2011 to determine if there were any signs of abuse, if patients felt they were treated well and asked if they had any complaints. No complaints were noted out of the 13 interviews. A timeline of interviews with summaries of events was prepared by Assistant Administrator and reported to the Administrator

Pursuant to the direction of the Administrator, commencing on Thursday, August 25th, 2011 and thru August 30th, 2011 Facility policies related to the prevention, investigation and reporting of abuse were reviewed and revised. Legal counsel was contacted on August 25, 2011 concerning revision of the policies and other matters.

Once Charleston became aware of the situation, the Administrator and the Assistant Administrator determined that changes in policy and additional training of staff was necessary. On Friday, August 26th, 2011 training was conducted for all staff including non-clinical staff during each shift (10am, 2pm, 4pm, and 11pm) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by key employees of the Facility including Marketing/PR Coordinator and Education Assistant; Assistant Administrator; and Co-Owner. Training session was overseen by the Administrator, Both and Mr. Brown received training from Jill Brown concerning abuse prevention, abuse

investigation and abuse reporting. The Director of Nursing, [redacted] RN was then trained by [redacted] regarding allegation of abuse, reporting of abuse and investigation process regarding abuse allegations. [redacted], Assistant Administrator and

[redacted] Administrator received training concerning abuse prevention, abuse investigation, and abuse reporting by legal counsel, [redacted] commencing August 25, 2011 and continuing through the present. Additional consultation was provided by [redacted] who is also legal counsel concerning the situation with [redacted], the alleged perpetrator commencing August 12, 2011. At the completion of the training for the staff, a written quiz was taken by each staff member to verify the employee's comprehension of the material. This training was given to all 150 current employees. Training concerning abuse prevention, abuse investigation and abuse reporting will be given to any new employees of the Facility upon date of hire. Further, the Facility currently has one employee on medical leave. This employee will receive training concerning abuse prevention, abuse investigation and abuse reporting upon returning from medical leave. The employees successfully completed the quiz and the results were reviewed [redacted] Administrator.

The Friday August 26th, 2011 training was given to all employees of the Facility even those without direct patient care duties. Charleston believes that any employee that may have contact with a resident and that all employees should be aware of the potential for abuse and should know how to report it in the event it is suspected or observed. As reported above, the training was conducted by key employees of Charleston including [redacted], Marketing/PR Coordinator and Education Assistant [redacted] Assistant Administrator; and [redacted] Co-owner. Both [redacted] and [redacted] received training from [redacted] concerning abuse prevention, abuse investigation and abuse reporting. [redacted], Assistant Administrator and

[redacted] Administrator received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel, [redacted]. In addition, please note that Charleston works with legal counsel [redacted] on a regular basis regarding regulatory compliance issues.

On Friday, August 26th, 2011 and August 30, 2011 each Department Head was specifically educated about the new policies and procedures emphasizing that potential abuse must be reported to both the Office of Inspector General and Adult Protective Services with the final results of an investigation communicated within five days. New tools have been developed for the use of Department Head staff. Verification of understanding of policies by Department Head staff was conducted by taking a quiz on the information received. The results of the quiz were reviewed by [redacted] Administrator and [redacted], Assistant Administrator, on the evening of Friday, August 26th, 2011. On Friday, August 26th, 2011 a checklist file was prepared and distributed to the department heads to assist them in following the correct procedures. Included in the Abuse Response Checklist is the Self-Reporting Form published by the Division of Health Care entitled "Long Term Care Facility-Self-Report Incident Form" along with the instructions. In addition, on the evening of August 30th, 2011 training regarding the emphasis of reporting suspected abuse was conducted by [redacted] Assistant Administrator, which was overseen and presented under the direction of [redacted]

Administrator, _____ and _____ received training from legal counsel, _____, regarding suspected abuse reporting requirements.

The Abuse Policy-Supervision of Staff related to Abuse Potential was updated and revised concerning a supervisory employee's start to monitor and evaluate employees who may have a greater potential for abuse of a resident. This policy was revised on Thursday, August 25, 2011, immediately upon notification of the immediate jeopardy. This policy also instructs an employee to advise his or her supervisor if he or she is having problems dealing with stress-whether personal or work related. Both supervisors and employees are reminded of the confidential nature of these communications to the extent that resident safety is not compromised. Training about the revised and existing policies related to abuse was conducted by key employees _____ Marketing/PR Coordinator and Education Assistant; _____, Assistant Administrator, and _____, Co-owner, which was approved and overseen by the Administrator, _____ and the Assistant Administrator, _____. Both _____ and _____ received their training from _____ concerning abuse prevention, abuse investigation, and abuse reporting. _____ and _____ received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

The Abuse Policy and Screening Procedure for Potential Employees was amended and approved by _____, Administrator, on the Thursday evening, August 25th 2011, to include a screening process for administration to use when hiring new employees so that the potential for abuse is specifically considered in addition to the criminal record checks, abuse registry screens, license verification, state registration verification and reference checks. In Addition, all revision and amendment to policies were reviewed and approved by _____ Administrator. The training was conducted by key employees of Charleston including Kay Thurman, Marketing/PR Coordinator and Education Assistant; _____, Assistant Administrator, and _____, Co-owner, who were overseen by the Administrator, _____. Both _____ and _____ received training from _____ Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting by legal counsel, _____. In addition please note that the Facility works on a continuous basis with Ms. _____ for training on regulatory compliance and is notified by _____ for training on regulatory compliance and is notified by _____ on any updates and/or changes to regulatory compliance issues.

The policies related to investigation were also reviewed and strengthened on the Thursday evening, August 25th, 2011 to make sure that investigations are carried out when reports of suspected abuse and abuse have been made as the investigation Protocol makes clear. These policies were reviewed and approved by _____ Administrator.

Continued training will be conducted on a bi-annual basis for all employees of Charleston Health Care Center. This training will include specifics regarding allegation of abuse, reporting of abuse, monitoring for signs of potential abuse and investigation procedures regarding alleged abuse. This training will be overseen and approved by _____

the Administrator, In addition, any new hires will receive the above referenced training upon date of employment. The Director of Nursing will review compliance with training requirements and will report any and all findings to the quality assurance committee on a quarterly basis, which will monitor Facility compliance. Because all residents may be at risk for harm of ages if it exists changes and improvements were made to policies and procedures concerning abuse prevention, abuse investigation, and abuse reporting, on a system-wide basis and all 150 current staff members were educated about the policies on Friday, August 26th, 2011. The training was conducted by key employees of the Facility including Marketing/PR Coordinator, and Education Assistant; Assistant Administrator; and _____, Co-owner, who were overseen by Administrator. Both Ms. Thurman and _____ received training from _____ concerning abuse prevention, abuse investigation and abuse reporting, and _____ received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Thursday evening, August 25, 2011, these policies include a specific provision that if a report of abuse is made that involves an employee, that employee will be reassigned from resident care to another job or suspended during the investigation. These charges were made to protect resident from retaliation or further acts of abuse.

As of Friday, August 26th, 2011, other policies have been implemented that are aimed at the protection of residents from abuse by employees. This includes training supervisory staff to recognize situation that may indicate stress on employees. Because individuals who are working under excessive emotional stress are more likely to be impatient they have a greater likelihood of committing abuse. The training was conducted by key employees of the Facility including Marketing/PR Coordinator, Co-owner, and Assistant Administrator. Both Ms. Thurman and Mr. _____ received training from _____, Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting. _____ received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Friday August 26th, 2011, Charleston has initiated new procedures to ensure compliance by these important changes to policies and procedures. Education of staff however is vital to insuring that everyone understands their duty to report suspected abuse and to whom it is to be reported. The training will continue on abuse prevention, abuse investigation, and abuse reporting on a bi-annual basis overseen by _____, Administrator. Also new staff will be thoroughly in-serviced by key employees of the Facility, overseen by Administrator, _____, on the policies and procedures pertaining to abuse, prevention, investigation, and reporting and importance of reporting requirement. In addition, the Facility and its administration believes that by incorporating the duty to be vigilant about employee stressors into the policies for supervisory employees and employees that staff will be more sensitive to situations that make staff more susceptible to acting in an abusive manner.

In addition, residents will be monitored on a daily basis by the treatment nurse for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse, who in turn is required to report the findings to the Director on Nursing, _____ RN, who then reports immediately to _____, Assistant Administrator, and _____ Administrator. _____, Assistant Administrator will then notify any and all appropriate State Agencies.

The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained. As of Thursday evening, August 25th, 2011, the Facility revised relevant policies and as of Friday, August 26th, 2011 has educated staff about those policies. The training was conducted by key employees of the Facility including _____ Marketing/PR Coordinator and Education Assistant, _____ Assistant Administrator; and _____ Co-owner under the supervision and direction of the Administrator _____ Both _____ and _____ received training for _____ concerning abuse prevention abuse investigation and abuse reporting. _____ received training concerning abuse prevention abuse investigation and abuse reporting by legal counsel _____. In addition, by creating the new tool for Department Heads, which walks the individual through the steps that should be taken when abuse is suspected or reported, the Facility is confident that its solution will be sustained. In addition all reports of suspected abuse are to be immediately reported and given to the charge nurse. The charge nurse will then immediately report the suspected abuse to the Director of Nursing and will record the allegation in the 24-hour nurses' report. The Director of Nursing and _____ Assistant Administrator, will review the 24-hour nurses' report on a daily basis and will report any alleged abuse in compliance with any and all regulatory requirement to _____, Administrator, and any and all state agencies necessary. This will insure that communication of suspected abuse as well as abuse is address and monitored by Facility Administration.

When abuse is suspected or discovered, the Administrator and the Assistant Administrator shall monitor the situation according to Facility policies to assure that any employee suspected to have perpetrated abuse will be suspended or reassigned from resident care duties until a full investigation has been completed and a determination reached, that all reports have been made, and that the situation has been appropriately documented. Additional monitoring will be carried out by the Quality Assurance Committee that receives all reports of suspected or actual abuse.

Additional in-service training was held on Friday September 16th, 2011, & Tuesday September 20th, 2011 with key department heads and licensed nurses. Training included abuse, abuse reporting, and abuse documentation. _____ Assistant Administrator presented training under the direction of _____ Administrator. _____ Administrator, and _____ Assistant Administrator have received continued education for legal counsel

A book of allegations and log of all abuse, abuse reporting, abuse documentation, abuse investigation if to be kept in the Administrator/Assistant Administrator's office. The book will be used for compliance, quality assurance, and record keeping. This book was started September 2, 2011.

The Facility was in substantial compliance on August 31, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #1 - The plan of correction fails to address corrective actions taken for residents identified in the deficient practice.

Please find attached as Exhibit 1, updated policies addressing abuse allegations.

Resident 1:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #1 did not suffer any abuse or harm either mental or physical. The following specific actions were accomplished for Resident #1:

- Head to toe skin assessment of Resident #1 was completed on 8/12/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse, or harm substantiated for Resident #1.
- Interview with Resident #1 was conducted on 8/12/11.
- Resident #1's family was notified of the alleged abuse and interviewed on 8/13/11. It is interesting that Resident #1's family was supportive of the alleged perpetrator, thought that he worked well with Resident #1, did not confirm any abusive behavior on the part of the employee, and did not note any physical or mental indications of abuse for Resident #1.

- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #1 based on the report of alleged abuse on 8/15/11 and determined that Resident #1 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.
- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. Initial training of staff was completed by 8/26/11 with additional training in September. In October, policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization and restatement of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.

- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented where allegations of abuse are recorded. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Education of Key Employees that include Administrator, DON, assistant director of nursing, social work director, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11 and again on 9/16/11, and 9/20/11.
- Random interviews of Residents were conducted to identify if any other potential abuse victims existed on 8/30/11.
- Procedures involving the proper recordkeeping for background checks so that only qualified employees with no reported instance of abuse are hired were reviewed. The Facility performs background checks for all staff, not just clinical staff. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures.
- The nursing staff was also educated about their respective duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse, etc. Specific training took place on 8/26/11, 9/16/11 and 9/20/11. Ongoing training is also provided.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.
- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes. Exhibit 3.

Resident 2:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #2 did not suffer any abuse either mental or physical. The following specific actions were accomplished for Resident #2:

- Head to toe skin assessment of Resident #1 was completed on 7/22/11 and on 8/17/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse or harm substantiated for Resident #2. Resident #2 has mental impairments that cause him to make statements that are imagined and without basis. It was determined that Resident #2's statements were not accurate.
- Interview with Resident #2 was conducted on 8/12/11.
- Resident #2's allegations of abuse occurred in July. At the time, staff notified Resident #2's family about his allegations. Later in July the DON personally communicated with Resident #2's family about his allegations. The family as well as Facility staff did not find the allegations to be true as a result of Resident #2's mental status and frequent statements that did not reflect reality. While Resident #2 did name the same CNA his statements were found to be untrue.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #2 based on the report of alleged abuse on 8/15/11 and determined that Resident #2 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.
- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.

- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. The policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional Education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.
- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented to record allegations of abuse. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Key employees include Administrator, director of nursing, assistant director of nursing, social work, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11.
- Random Interviews of Residents were conducted to identify any other potential abuse victims existed on 8/30/11.
- Proper record check/keeping to identify safe employees upon hire. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures. The nursing staff was also educated about their duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse. etc.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.

- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes.

Criteria # 4 - The plan of correction failed to include specifics/details related to monitoring.

Charleston will monitor its performance on an on-going basis to assure that its Facility Policies and Procedures are implemented in a timely and effective manner. The treatment nurse has been assigned the responsibility of monitoring each shift, (24 hours per day, 7 days per week) for any reports of allegations of abuse. When reported, the treatment nurse is to initiate procedures in a manner consistent with Facility policies and procedures.

- The Facility has implemented a process that includes shared staff responsibility for timely reporting, investigating, addressing, and monitoring allegations of abuse. By assigning the treatment nurse, the charge nurse, and the DON to report allegations of abuse, effective compliance will be maintained. Date: 9/21/11.
- All Facility staff has been educated about the policies and procedures to be followed when abuse is discovered/reported or allegations of abuse are made. Dates: 8/25/11, 9/16/11, and 9/20/11.
- All Certified Nursing Assistants ("CNA") have the duty to report any allegations, symptoms, or signs of abuse to charge nurse immediately upon discovery; staff has been extensively educated about this duty. Dates: 8/25/11, 9/16/11, and 9/20/11.
- Nursing staff assigned the duties of treatment nurse is required to undertake a specific review of patients and staff for reports of abuse or potential abuse and is to report the same to charge nurse each shift.

- The Charge Nurse has the duty to report allegations of abuse to DON during business hours and if allegations are reported after business hours; the charge nurse is to report the allegations to the Administrator or assistant Administrator when received after business hours.
- The Administrator is to follow up within 48 hours of any report of alleged abuse to determine and verify all policies and procedures regarding alleged abuse were followed and that the investigation has been completed;
- Clinical staff shall assess and identify residents who may have the potential for abusive behavior and this shall be addressed through care planning and monitoring of residents with needs and behaviors that may lead to conflict or neglect.
- Any residents identified as having the potential for abusive behavior through care planning and monitoring will be reported to charge nurse each shift; the charge nurse will then report this information to the Administrator.
- To assure further compliance with monitoring, the Facility has arranged for qualified psychiatrist and other mental health professionals to help the staff manage difficult or aggressive residents.
- Random head to toe examinations, in addition to scheduled skin assessments for residents, will be conducted on a monthly basis by nursing staff. Any signs of abuse will be immediately reported to the charge nurse on duty, which will immediately report the findings to the administration.
- Continuous monitoring will all occur through interviews with visitors, family, volunteers, that will be conducted monthly.
- DON and Assistant Administrator and/or Administrator will meet five times a week specifically to discuss whether any allegations of abuse have been reported or any signs of abuse noted by staff for any resident.
- Daily meeting of the key employees (that include Department Heads, Administrator, Assistance Administrator, MDS Coordinator, DON, Activities Director, Social Services, Dietary, Restorative Nurse, Office Manager and Housekeeping and Laundry) will occur to address concerns and identify problems including any reports of abuse or alleged abuse.
- Monitoring and review of abuse allegations and investigations has been added to Quality Assurance Committee's duties; the Administrator will designate a clinical staff member to monitor and supervise each allegation

of abuse that is received prior to the QA meeting to determine whether Facility procedures and policies have been followed in a timely manner.

- Administrator or his delegate has the responsibility to perform and/or supervise the investigation, to make proper and timely reports, and to document satisfactory resolution of abuse allegations. To facilitate timely supervision, a log shall be kept in the Administrator's office that records every allegation of abuse and a tool to determine that Facility policies and procedures have been followed in a timely manner. This book will contain all information IE, incident report, statements, nurses notes, 24 report, face sheet of resident, MDS, self-report to OIG, fax confirmation, final report, receipt of report to Adult Protective Services along with a log indicating when the action has been taken;
- The Administrator and Assistant Administrator are responsible for reviewing the log book to determine and monitor compliance with regulations and Facility Policies and Procedures. In addition, the Administrator and Assistant Administrator are responsible for making all reports of allegations of abuse and findings, and for completing the investigation within 5 days with the help of key employees. The Administrator shall report the results of all investigations of abuse in timely manner as required by Facility policy and procedure as well as state law.

Criteria #5 – The completion date is prior to the survey exit date.

To address the concerns of the Office of Inspector General, the Facility has revised the Plan of Corrections as previously submitted. Although the Plan of Correction has been supplemented, the Facility achieved substantial compliance as of 8/31/11. Even though Charleston has taken additional steps including reorganization and restating of abuse policies and procedures on 10/12/11 and the staff was educated on the reorganized and restated policies with written copies of the new policies distributed on 10/13/11. The survey was completed on 9/30/11 and the immediate jeopardy was removed on 8/31/11 even though the original Plan of Corrections has been supplemented, Charleston achieved substantial compliance on 8/31/11.

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alleged perpetrator, was terminated as of August 12, 2011 before 11 AM when the matter was brought to the attention of Human Resources Director and communicated to the Administrator Assistant Administrator was instructed by to terminate the employee. The employee was terminated within the hour.

Pursuant to the direction of the Administrator, immediate investigation of events began on the evening of August 12th, 2011 as soon as Charleston terminated (alleged perpetrator) employment as directed. Nursing staff conducted physical

examinations of residents in the care of _____ for the week August 6th 2011 and including up to August 12th, 2011 to determine if any possible abuse had occurred.

Assistant Administrator and _____ HR Coordinator, also conducted interviews on the evening of August 12th 2011 with all staff members who may have had information regarding this allegation. The investigation of possible abuse of residents continued as interviews of family members and alert and oriented residents were conducted on August 30, 2011. Resident interviews were conducted by clinical staff that included _____, LPN and _____, RN who specifically inquired of residents about possible abuse. Family and visitor interviews (13), which included family members on non-oriented patients, were conducted by _____ Assistant Administrator and _____ Co-Owner on the afternoon of August 30, 2011 to determine if there were any signs of abuse, if patients felt they were treated well and asked if they had any complaints. No complaints were noted out of the 13 interviews. A timeline of interviews with summaries of events was prepared by _____ Assistant Administrator and reported to the Administrator

Pursuant to the direction of the Administrator, commencing on Thursday, August 25th, 2011 and thru August 30th, 2011 Facility policies related to the prevention, investigation and reporting of abuse were reviewed and revised. Legal counsel was contacted on August 25, 2011 concerning revision of the policies and other matters.

Once Charleston became aware of the situation, the Administrator and the Assistant Administrator determined that changes in policy and additional training of staff was necessary. On Friday, August 26th, 2011 training was conducted for all staff including non-clinical staff during each shift (10am, 2pm, 4pm, and 11pm) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by key employees of the Facility including _____ Marketing/PR Coordinator and Education Assistant; _____ Assistant Administrator; and _____ Co-Owner. Training session was overseen by the Administrator, _____ Both _____ and _____ received training from _____ concerning abuse prevention, abuse investigation and abuse reporting. The Director of Nursing, _____ RN was then trained by _____ regarding allegation of abuse, reporting or abuse and investigation process regarding abuse allegations. _____ Assistant Administrator and _____ Administrator received training concerning abuse prevention, abuse investigation, and abuse reporting by legal counsel, _____ commencing August 25, 2011 and continuing through the present. Additional consultation was provided by _____, legal counsel, concerning the situation with _____ the alleged perpetrator commencing August 12, 2011. At the completion of the training for the staff, a written quiz was taken by each staff member to verify the employee's comprehension of the material. This training was given to all 150 current employees. Training concerning abuse prevention, abuse investigation and abuse reporting will be given to any new employees of the Facility upon date of hire. Further, the Facility currently has one employee on medical leave. This employee will receive training concerning abuse prevention, abuse investigation and abuse reporting upon returning from medical leave. The employees successfully completed the quiz and the results were reviewed by _____ Administrator.

The Friday August 26y, 2011 training was given to all employees of the Facility even those without direct patient care duties. Charleston believes that any employee that may have contact with a resident and that all employees should be aware of the potential for abuse and should know how to report it in the event it is suspected or observed. As reported above, the training was conducted by key employees of Charleston including Marketing/PR Coordinator and Education Assistant Assistant Administrator; and , Co-owner. Both and received training from concerning abuse prevention, abuse investigation and abuse reporting. , Assistant Administrator and Administrator received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel, In addition, please note that Charleston works with legal counsel, on a regular basis regarding regulatory compliance issues.

On Friday, August 26th, 2011 and August 30, 2011 each Department Head was specifically educated about the new policies and procedures emphasizing that potential abuse must be reported to both the Office of Inspector General and Adult Protective Services with the final results of an investigation communicated within five days. New tools have been developed for the use of Department Head staff. Verification of understanding of policies by Department Head staff was conducted by taking a quiz on the information received. The results of the quiz were reviewed by Administrator and Assistant Administrator, on the evening of Friday, August 26th, 2011. On Friday, August 26th, 2011 a checklist file was prepared and distributed to the department heads to assist them in following the correct procedures. Included in the Abuse Response Checklist is the Self-Reporting Form published by the Division of Health Care entitled "Long Term Care Facility-Self-Report Incident Form" along with the instructions. In addition, on the evening of August 30th, 2011 training regarding the emphasis of reporting suspected abuse was conducted by , Assistant Administrator, which was overseen and presented under the direction of Administrator. and ; received training from legal counsel, , regarding suspected abuse reporting requirements.

The Abuse Policy-Supervision of Staff related to Abuse Potential was updated and revised concerning a supervisory employee's start to monitor and evaluate employees who may have a greater potential for abuse of a resident. This policy was revised on Thursday, August 25, 2011, immediately upon notification of the immediate jeopardy. This policy also instructs an employee to advise his or her supervisor if he or she is having problems dealing with stress-whether personal or work related. Both supervisors and employees are reminded of the confidential nature of these communications to the extent that resident safety is not compromised. Training about the revised and existing policies related to abuse was conducted by key employees Marketing/PR Coordinator and Education Assistant; Assistant Administrator, and , Co-owner, which was approved and overseen by the Administrator, and the Assistant Administrator, . Both and received their training from concerning abuse prevention, abuse investigation, and abuse reporting. and

received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel, Lisa English Hinkle.

The Abuse Policy and Screening Procedure for Potential Employees was amended and approved by _____ Administrator, on the Thursday evening, August 25th 2011, to include a screening process for administration to use when hiring new employees so that the potential for abuse is specifically considered in addition to the criminal record checks, abuse registry screens, license verification, state registration verification and reference checks. In Addition, all revision and amendment to policies were reviewed and approved by _____ Administrator. The training was conducted by key employees of Charleston including _____ Marketing/PR Coordinator and Education Assistant; _____ Assistant Administrator, and _____ Co-owner, who were overseen by the Administrator. Both _____ and _____ received training from _____ Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

In addition please note that the Facility works on a continuous basis with _____ for training on regulatory compliance and is notified by _____ for training on regulatory compliance and is notified by _____ on any updates and/or changes to regulatory compliance issues.

The policies related to investigation were also reviewed and strengthened on the Thursday evening, August 25th, 2011 to make sure that investigations are carried out when reports of suspected abuse and abuse have been made as the investigation Protocol makes clear. These policies were reviewed and approved by _____ Administrator.

Continued training will be conducted on a bi-annual basis for all employees of Charleston Health Care Center. This training will include specifics regarding allegation of abuse, reporting of abuse, monitoring for signs of potential abuse and investigation procedures regarding alleged abuse. This training will be overseen and approved by the Administrator, _____ In addition, any new hires will receive the above referenced training upon date of employment. The Director of Nursing will review compliance with training requirements and will report any and all findings to the quality assurance committee on a quarterly basis, which will monitor Facility compliance.

Because all residents may be at risk for harm of ages if it exists changes and improvements were made to policies and procedures concerning abuse prevention, abuse investigation, and abuse reporting, on a system-wide basis and all 150 current staff members were educated about the policies on Friday, August 26th, 2011. The training was conducted by key employees of the Facility including _____ Marketing/PR Coordinator, and Education Assistant; _____ Assistant Administrator; and _____, Co-owner, who were overseen by _____ Administrator. Both _____ and _____ received training from _____ concerning abuse prevention, abuse investigation and abuse reporting. _____ and _____ received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Thursday evening, August 25, 2011, these policies include a specific provision that if a report of abuse is made that involves an employee, that employee will be reassigned from resident care to another job or suspended during the investigation. These charges were made to protect resident from retaliation or further acts of abuse.

As of Friday, August 26th, 2011, other policies have been implemented that are aimed at the protection of residents from abuse by employees. This includes training supervisory staff to recognize situation that may indicate stress on employees. Because individuals who are working under excessive emotional stress are more likely to be impatient they have a greater likelihood of committing abuse. The training was conducted by key employees of the Facility including Marketing/PR Coordinator, Co-owner, and Assistant Administrator. Both and received training from , Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting. received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Friday August 26th, 2011, Charleston has initiated new procedures to ensure compliance by these important changes to policies and procedures. Education of staff however is vital to insuring that everyone understands their duty to report suspected abuse and to whom it is to be reported. The training will continue on abuse prevention, abuse investigation, and abuse reporting on a bi-annual basis overseen by

Administrator. Also new staff will be thoroughly in-serviced by key employees of the Facility, overseen by Administrator, on the policies and procedures pertaining to abuse, prevention, investigation, and reporting and importance of reporting requirement. In addition, the Facility and its administration believes that by incorporating the duty to be vigilant about employee stressors into the policies for supervisory employees and employees that staff will be more sensitive to situations that make staff more susceptible to acting in an abusive manner.

In addition, residents will be monitored on a daily basis by the treatment nurse for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse, who in turn is required to report the findings to the Director on Nursing, , RN, who then reports immediately to , Assistant Administrator, and Administrator.

Assistant Administrator will then notify any and all appropriate State Agencies.

The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained. As of Thursday evening, August 25th, 2011, the Facility revised relevant policies and as of Friday, August 26th, 2011 has educated staff about those policies. The training was conducted by key employees of the Facility including Marketing/PR Coordinator and Education Assistant, Assistant Administrator; and Co-owner under the supervision and direction of the Administrator Both and received training for concerning abuse prevention abuse investigation and

abuse reporting. received training concerning abuse prevention abuse investigation and abuse reporting by legal counsel In addition, by creating the new tool for Department Heads, which walks the individual through the steps that should be taken when abuse is suspected or reported, the Facility is confident that its solution will be sustained. In addition all reports of suspected abuse are to be immediately reported and given to the charge nurse. The charge nurse will then immediately report the suspected abuse to the Director of Nursing and will record the allegation in the 24-hour nurses' report. The Director of Nursing and Jill Brown, Assistant Administrator, will review the 24-hour nurses' report on a daily basis and will report any alleged abuse in compliance with any and all regulatory requirement to Administrator, and any and all state agencies necessary. This will insure that communication of suspected abuse as well as abuse is address and monitored by Facility Administration.

When abuse is suspected or discovered, the Administrator and the Assistant Administrator shall monitor the situation according to Facility policies to assure that any employee suspected to have perpetrated abuse will be suspended or reassigned from resident care duties until a full investigation has been completed and a determination reached, that all reports have been made, and that the situation has been appropriately documented. Additional monitoring will be carried out by the Quality Assurance Committee that receives all reports of suspected or actual abuse.

Additional in-service training was held on Friday September 16th, 2011, & Tuesday September 20th, 2011 with key department heads and licensed nurses. Training included abuse, abuse reporting, and abuse documentation. Assistant Administrator presented training under the direction of Administrator. Administrator, and Assistant Administrator have received continued education for legal counsel

A book of allegations and log of all abuse, abuse reporting, abuse documentation, abuse investigation if to be kept in the Administrator/Assistant Administrator's office. The book will be used for compliance, quality assurance, and record keeping. This book was started September 2, 2011.

The Facility was in substantial compliance on August 31, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #1 - The plan of correction fails to address corrective actions taken for residents identified in the deficient practice.

Please find attached as Exhibit 1, updated policies addressing abuse allegations.

Resident 1:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #1 did not suffer any abuse or harm either mental or physical. The following specific actions were accomplished for Resident #1:

- Head to toe skin assessment of Resident #1 was completed on 8/12/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse, or harm substantiated for Resident #1.
- Interview with Resident #1 was conducted on 8/12/11.
- Resident #1's family was notified of the alleged abuse and interviewed on 8/13/11. It is interesting that Resident #1's family was supportive of the alleged perpetrator, thought that he worked well with Resident #1, did not confirm any abusive behavior on the part of the employee, and did not note any physical or mental indications of abuse for Resident #1.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #1 based on the report of alleged abuse on 8/15/11 and determined that Resident #1 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective

tool to communicate information between the clinical staff and the Administration. Exhibit 2.

- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. Initial training of staff was completed by 8/26/11 with additional training in September. In October, policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization and restatement of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.
- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented where allegations of abuse are recorded. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Education of Key Employees that include Administrator, DON, assistant director of nursing, social work director, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11 and again on 9/16/11, and 9/20/11.
- Random interviews of Residents were conducted to identify if any other potential abuse victims existed on 8/30/11.
- Procedures involving the proper recordkeeping for background checks so that only qualified employees with no reported instance of abuse are hired were reviewed. The Facility performs background checks for all staff, not

just clinical staff. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures.

- The nursing staff was also educated about their respective duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse, etc. Specific training took place on 8/26/11, 9/16/11 and 9/20/11. Ongoing training is also provided.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.
- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes. Exhibit 3.

Resident 2:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #2 did not suffer any abuse either mental or physical. The following specific actions were accomplished for Resident #2:

- Head to toe skin assessment of Resident #1 was completed on 7/22/11 and on 8/17/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse or harm substantiated for Resident #2. Resident #2 has mental impairments that cause him to make statements that are imagined and without basis. It was determined that Resident #2's statements were not accurate.
- Interview with Resident #2 was conducted on 8/12/11.

- Resident #2's allegations of abuse occurred in July. At the time, staff notified Resident #2's family about his allegations. Later in July the DON personally communicated with Resident #2's family about his allegations. The family as well as Facility staff did not find the allegations to be true as a result of Resident #2's mental status and frequent statements that did not reflect reality. While Resident #2 did name the same CNA his statements were found to be untrue.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #2 based on the report of alleged abuse on 8/15/11 and determined that Resident #2 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.
- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. The policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional Education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical

Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.

- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented to record allegations of abuse. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Key employees include Administrator, director of nursing, assistant director of nursing, social work, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11.
- Random Interviews of Residents were conducted to identify any other potential abuse victims existed on 8/30/11.
- Proper record check/keeping to identify safe employees upon hire. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures. The nursing staff was also educated about their duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse. etc.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.
- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes.

Criteria # 4 - The plan of correction failed to include specifics/details related to monitoring.

Charleston will monitor its performance on an on-going basis to assure that its Facility Policies and Procedures are implemented in a timely and effective manner. The treatment nurse has been assigned the responsibility of monitoring each shift, (24 hours per day, 7 days per week) for any reports of allegations of abuse. When reported, the treatment nurse is to initiate procedures in a manner consistent with Facility policies and procedures.

- The Facility has implemented a process that includes shared staff responsibility for timely reporting, investigating, addressing, and monitoring allegations of abuse. By assigning the treatment nurse, the charge nurse, and the DON to report allegations of abuse, effective compliance will be maintained. Date: 9/21/11.
- All Facility staff has been educated about the policies and procedures to be followed when abuse is discovered/reported or allegations of abuse are made. Dates: 8/25/11, 9/16/11, and 9/20/11.
- All Certified Nursing Assistants ("CNA") have the duty to report any allegations, symptoms, or signs of abuse to charge nurse immediately upon discovery; staff has been extensively educated about this duty. Dates: 8/25/11, 9/16/11, and 9/20/11.
- Nursing staff assigned the duties of treatment nurse is required to undertake a specific review of patients and staff for reports of abuse or potential abuse and is to report the same to charge nurse each shift.
- The Charge Nurse has the duty to report allegations of abuse to DON during business hours and if allegations are reported after business hours; the charge nurse is to report the allegations to the Administrator or assistant Administrator when received after business hours.
- The Administrator is to follow up within 48 hours of any report of alleged abuse to determine and verify all policies and procedures regarding alleged abuse were followed and that the investigation has been completed;
- Clinical staff shall assess and identify residents who may have the potential for abusive behavior and this shall be addressed through care planning and monitoring of residents with needs and behaviors that may lead to conflict or neglect.
- Any residents identified as having the potential for abusive behavior through care planning and monitoring will be reported to charge nurse each shift; the charge nurse will then report this information to the Administrator.

- To assure further compliance with monitoring, the Facility has arranged for qualified psychiatrist and other mental health professionals to help the staff manage difficult or aggressive residents.
- Random head to toe examinations, in addition to scheduled skin assessments for residents, will be conducted on a monthly basis by nursing staff. Any signs of abuse will be immediately reported to the charge nurse on duty, which will immediately report the findings to the administration.
- Continuous monitoring will all occur through interviews with visitors, family, volunteers, that will be conducted monthly.
- DON and Assistant Administrator and/or Administrator will meet five times a week specifically to discuss whether any allegations of abuse have been reported or any signs of abuse noted by staff for any resident.
- Daily meeting of the key employees (that include Department Heads, Administrator, Assistance Administrator, MDS Coordinator, DON, Activities Director, Social Services, Dietary, Restorative Nurse, Office Manager and Housekeeping and Laundry) will occur to address concerns and identify problems including any reports of abuse or alleged abuse.
- Monitoring and review of abuse allegations and investigations has been added to Quality Assurance Committee's duties; the Administrator will designate a clinical staff member to monitor and supervise each allegation of abuse that is received prior to the QA meeting to determine whether Facility procedures and policies have been followed in a timely manner.
- Administrator or his delegate has the responsibility to perform and/or supervise the investigation, to make proper and timely reports, and to document satisfactory resolution of abuse allegations. To facilitate timely supervision, a log shall be kept in the Administrator's office that records every allegation of abuse and a tool to determine that Facility policies and procedures have been followed in a timely manner. This book will contain all information IE, incident report, statements, nurses notes, 24 report, face sheet of resident, MDS, self-report to OIG, fax confirmation, final report, receipt of report to Adult Protective Services along with a log indicating when the action has been taken;
- The Administrator and Assistant Administrator are responsible for reviewing the log book to determine and monitor compliance with regulations and Facility Policies and Procedures. In addition, the Administrator and Assistant Administrator are responsible for making all reports of allegations of abuse and findings, and for completing the investigation within 5 days with the help of key employees. The

Administrator shall report the results of all investigations of abuse in timely manner as required by Facility policy and procedure as well as state law.

Criteria #5 – The completion date is prior to the survey exit date.

To address the concerns of the Office of Inspector General, the Facility has revised the Plan of Corrections as previously submitted. Although the Plan of Corrections has been supplemented, the Facility achieved substantial compliance as of 8/31/11. Even though Charleston has taken additional steps including reorganization and restating of abuse policies and procedures on 10/12/11. The staff was educated on the reorganized and restated policies with written copies of the new policies distributed on 10/13/11. The survey was completed on 9/1/11 and the immediate jeopardy was removed on 8/31/11 even though the original Plan of Corrections has been supplemented, Charleston achieved substantial compliance on 8/31/11.

F253

Charleston will provide the housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

Facility reviewed and revised Wheelchair Cleaning Procedure on September 1, 2011. Laundry/Housekeeping Supervisor, _____ meet with all laundry/housekeeping staff regarding new policy and education regarding to keeping not only wheelchairs but all equipment, building, clothes, ETC. Sanitary, orderly and comfortable.

Housekeeping/Laundry Supervisor is to monitor daily to ensure compliance. In addition, a log will be kept noting when wheelchairs are cleaned, date, time, and by whom.

The Facility was in substantial compliance on September 2, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") for all services to be provided or arranged by the Facility to be provided by qualified persons in accordance with each resident's written plan of care.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #1

- Resident # 4's wheelchair was immediately cleaned by housekeeping when brought to the attention of staff by state surveyors.

- Wheelchair Policies and Procedures were updated on 9/1/11. See Attached Exhibit 4.
- Laundry and Housekeeping Staff were educated about the Wheelchair Policies and Procedures and their respective duties thereunder on 9/1/11.
- Clinical staff was advised of the policy changes and their responsibility to report soiled or non-functioning wheelchairs to housekeeping supervisor on 9/1/11.
- Laundry and Housekeeping Supervisor were assigned the task of keeping a written log to confirm the cleaning of each wheelchair and the date of the cleaning starting on 9/1/11.

Criteria #3

Laundry and Housekeeping Supervisor will keep an inventory of all wheelchairs. The Supervisor will assure timely and efficient routines and cleaning patterns to verify that each wheelchair has been cleaned weekly. If a wheelchair becomes soiled before the scheduled cleaning date, it will be cleaned immediately and documented in the Supervisor's written log.

Policies and Procedures were updated to reflect these changes. These Policies and Procedures were completed 10/12/11. See attached Exhibit 4.

F282

An updated list of residents who require the use of a magnetic pull away alarm for personal safety has been in use. MARS are noted to check for placement and function on every shift. Lists are placed at each nurse's desk into each group book and copies are kept in the DON's office. As census changes as will as part of the end of month procedure.

ALL SRNA information Care sheets have been reviewed for notation that alarm is to be used and completed if needed. This was completed on 9-24-11.

MARS were also checked for notation "Bed/Chair" alarm-check every shift for placement and function. Completed 9-24-11.

The resident safety quality assurance record will be utilized for compliance. Information is to be obtained per nursing administration directives. This will be done weekly X4, monthly X4, and then quarterly.

Education and Training regarding residents' safety will be completed by 10-1-11 for licensed nurses and SRNA's Residents' beds will be noted with a sticker indicating that a Bed/Chair alarm is to be used. Completion date 10-1-11.

The Facility will be in substantial compliance on October 1, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to ensure residents who enter the Facility without pressure sores do not develop them, unless a resident's clinical condition makes them unavoidable.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #4

- The DON is responsible for monitoring the compliance of magnetic pull away alarms for safety (bed/chair alarm). The DON may advise and direct clinical staff to help her in assuring monitoring and compliance. All reports shall be made to the DON.
- Clinical staff is responsible for checking the operation and placement of bed/chair alarms. Any nonfunctioning alarm is to be reported to the DON immediately.
- To monitor compliance, the DON or delegated key employee shall perform random checks on a daily basis of residents who use bed/chair alarms. The Administrator or delegated individual shall confirm with the DON that monitoring of operation and placement of bed/chair alarms is being performed. See Exhibit 5.

F314

All resident records were reviewed to determine if a skin assessment was completed. This was completed on 9-21-11 with no negative findings. A new policy regarding skin assessments was developed on 9-21-11 along with a checklist to assure compliance with the new policy. The checklist will also serve as a Quality Assurance Measure and become effective 9-21-11. This will be Monitored on an on-going basis by nursing administration for completion on a weekly basis by signing and dating the checklist.

An in-service for all licensed nurses will be completed by October 1, 2011 to include review of the new policy, checking as well as Pressure Ulcer Prevention, wound care and Identification of stage-able pressure ulcers.

The Facility will be in compliance on October 1, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission

that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to ensure that the resident environments remain as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #1

- Immediate completion of the missing skin assessments were performed for Resident # 8 and Resident # 20 on 8/31/11. Based upon the assessment, appropriate skin treatments were implemented and in place for Resident #8 and Resident #20 on 8/31/11.

Criteria #2

To identify and assure that no other residents were affected by the alleged deficient practice pertaining to treatment prevention, healing of pressure sores and documentation of same, staff performed a complete audit of skin assessment documentation for all residents, which was conducted beginning 8/31/11 and completed 9/21/11, with no negative findings. In addition, all licensed nurses were educated regarding new policies pertaining to pressure ulcer prevention, wound care, and identification of stageable pressure ulcers. All education was completed by 10/1/11.

Criteria #4

A checklist was developed to assure compliance with new policies and to monitor the timely completion of skin assessments.

- The DON is responsible for monitoring the completion of skin assessments by clinical staff on a daily basis. For skin assessments completed over the weekend, the DON will review for completion on Monday.
- Monitoring of the performance of skin assessments is an ongoing responsibility of the DON, who is to check this on a daily basis and determine that skin assessments are being performed by individual residents as they become due.
- DON will notify the MDS Coordinator immediately if any changes in skin have occurred with the resident. For continued assurance, the DON will also report all changes to the QA Committee. See Exhibit 6.

F323

Water temperature was corrected the morning of August 30, 2011 by 11am.

Charleston contacted outside professional service for assistance with water temperature issue. Water temperature gauge was installed at hot water source and tempering value was adjusted to bring hot water temperature levels into compliance for safety.

Hot water temperature was checked in all affected patient bathrooms and room to insure resident safety and compliance.

Inspector's checked water temperature, hot water temperatures in resident's bathrooms and rooms to ensure resident safety and compliance before the exit of survey.

Hot water temperatures were recorded and found to be within a range of 103 degrees fahrenheit -104 degrees fahrenheit in affected rooms.

New emersion style thermometers were purchased for maintenance to accurately check water temperatures in all resident areas. Thermometers were put in use on Monday September 5th, 2011.

Source temperatures will be checked Monday thru Friday at hot water source. Water temperature room checks will continue to be monthly to ensure safety and compliance.

Safety of water temperature's was reviewed and revised 9-26-11.

The Facility was in substantial compliance on August 30, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food under sanitary conditions.

Criteria #1

Corrective action was taken for residents in rooms 11, 13, 19, 35, 37, and 104 on 8/31/11. The Maintenance Department identified and secured loose wires hanging from the ceilings in rooms 35 and 37 on 8/31/11. In addition, television cords in rooms 11, 13, 19, 103, and 104 were secured to assure safety on 8/31/11. Each resident's room was reviewed and corrected.

Criteria #2

On 9/1/11, all clinical staff was notified of a maintenance log book that will be kept at each nurses' station in which they are to immediately report any broken, or faulty equipment immediately. See Exhibit 7. On 9/2/11, a complete maintenance check of the entire Facility property, including resident rooms and resident areas, was made by _____ Director of Physical Plant and Maintenance Supervisor. No other safety issues were found. Daily checks of the Facility property checks will be conducted by the Maintenance Supervisor to assure safety and compliance. Any issues found will be immediately reported to the Administrator and will be properly addressed.

Criteria #3

On 9/5/11, maintenance staff was educated by _____, Director of Physical Plant, regarding the importance of safety in resident rooms with regards to protruding sharp wires, cables, water temperature safety, etc. In addition, on 10/6/11, _____ was educated by legal counsel regarding water temperature safety. Thereafter, maintenance staff was educated by _____ on 10/6/11. Systemic changes have been enforced to assure compliance and safety for each resident. A complete check of Facility property, including resident rooms and resident areas, was conducted by _____, Director of Physical Plant and _____ Maintenance Supervisor was conducted. No other safety issues were identified on 9/2/11. The Facility staff will perform daily checks of the Facility property including resident rooms and resident areas to assure compliance. This will be monitored by the Administrator on a weekly basis.

Criteria #4

A Maintenance Request Log has been placed at each nurse's station and all maintenance requests shall be recorded on the Maintenance Request Log. The Administrator will review the Maintenance Request Log on a weekly basis to assure that all maintenance requests have been addressed. A memo was posted about appropriate identification, and documentation in the maintenance request log books on September 1, 2011. In addition, Maintenance staff will survey the plant, operation, resident rooms, and resident common areas at the beginning of each shift, and again before they leave each day to assure compliance and resident safety. _____, Director of Physical Plant, will also monitor safety on a daily basis.

Criteria #5

To address the concerns of the Office of Inspector General, the Facility has revised the Plan of Corrections as previously submitted. Although the Plan of Correction has been supplemented, the Facility achieved substantial compliance as of 8/31/11. Even though Charleston has taken additional steps including updating policies and procedures for checking water temperatures on 9/26/11, all

new thermometers were in place at that time on 9/26/11, and maintenance staff was educated on 9/5/11 and 10/6/11 regarding water temperature safety.

The survey was completed on 9/30/11 and the immediate jeopardy was removed on 8/31/11 even though the original Plan of Corrections has been supplemented, Charleston achieved substantial compliance on 8/31/11.

F371

A mandatory in-service was conducted on September 7th, 2011 by RDLD. During the in-service employees were educated on the importance of wearing a hair restraint/hair net, covering hair entirely, hair care, personal hygiene & general sanitation review.

Daily rounds in Dietary Administration to check that hair is fully covered by hair restraint/hair net are being done.

A larger size hair restraint/hair net was ordered on September 7th, 2011. In addition bobby pins are on hand for all dietary employees's to be worn in conjunction with hair restraint/net.

Employees with long hair will double hair restraint/net, and then secure with bobby pins.

The new dietary action plan for hair restraint/net was completed on September 9, 2011.

The Facility was in substantial compliance on September 7, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Criteria #4

Infection control will be monitored for compliance using a quality assurance form beginning 9/26/11. See attached Exhibit 8. The DON will be responsible for monitoring for compliance regarding infection control. To assure compliance, actual observation of staff will be required from the DON or clinical staff appointed and trained by the DON, which will be done four times a week; four times a month and once a quarter by a licensed nurse designated by Nursing Administration. The DON will record findings on the new form and report all findings to the quality assurance committee on a quarterly basis. Additional

training will be given per policy, particularly when non-compliance is documented by the DON.

F441

SRNA #2 is no longer an employee of Charleston Health Care Center. Nurse #10 was given a written counseling on 9-2-11.

A new employee checklist devised on 9-23-11 to include observed incontinence care by a licensed nurse and/or nursing administration during the orientation period.

This form is to be obtained from the Director of Nursing upon employment and reported to her at the conclusion of the orientation period. At this time concerns and or questions will be addressed.

An in-service will be given to all SRNA's and licensed nurses in relation to infection control, incontinence care and use of plastic bags, observation of incontinence care by a licensed nurse began 9-21-11. This will be ongoing, unannounced, and done monthly on each shift using an infection control form which will also serve as quality assurance.

This will be completed by 10-1-11.

Nurse #10 was given a written counseling 9-21-11.

The policy for cleaning and sanitizing the glucometer was revised on 9-21-11. See attached.

Monitoring for compliance will be done utilizing a quality assurance form for infection control related to glucometer cleaning beginning 9-26-11.

This will be done weekly times four; monthly times four, then quarterly by a licensed nurse as directed by Nursing Administration. Actual observation will be necessary.

An in-service for all licensed nurses will be given on or before 10-1-11.

The Facility was in substantial compliance by October 1, 2011.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Charleston Health Care Center ("Charleston") to administer its Facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

Criteria #4

Infection control will be monitored for compliance using a quality assurance form beginning 9/26/11. See attached Exhibit 9. The DON will be responsible for monitoring for compliance regarding infection control. To assure compliance, actual observation of staff will be required from the DON or clinical staff appointed and trained by the DON, which will be done four times a week; four times a month and once a quarter by a licensed nurse designated by Nursing

Administration. The DON will record findings on the new form and report all findings to the quality assurance committee on a quarterly basis. Additional training will be given per policy, particularly when non-compliance is documented by the DON.

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alleged perpetrator, was terminated as of August 12, 2011 before 11 AM when the matter was brought to the attention of Human Resources Director and communicated to the Administrator Assistant Administrator was instructed by Mr. Sparks to terminate the employee. The employee was terminated within the hour.

Pursuant to the direction of the Administrator, immediate investigation of events began on the evening of August 12th, 2011 as soon as Charleston terminated (alleged perpetrator) employment as directed. Nursing staff conducted physical examinations of residents in the care of for the week August 6th 2011 and including up to August 12th, 2011 to determine if any possible abuse had occurred.

Assistant Administrator and HR Coordinator, also conducted interviews on the evening of August 12, 2011 with all staff members who may have had information regarding this allegation. The investigation of possible abuse of residents continued as interviews of family members and alert and oriented residents were conducted on August 30, 2011. Resident interviews were conducted by clinical staff that included LPN and RN who specifically inquired of residents about possible abuse. Family and visitor interviews (13), which included family members on non-oriented patients, were conducted by Assistant Administrator and Co-Owner on the afternoon of August 30, 2011 to determine if there were any signs of abuse, if patients felt they were treated well and asked if they had any complaints. No complaints were noted out of the 13 interviews. A timeline of interviews with summaries of events was prepared by Assistant Administrator and reported to the Administrator

Pursuant to the direction of the Administrator, commencing on Thursday, August 25th, 2011 and thru August 30th, 2011 Facility policies related to the prevention, investigation and reporting of abuse were reviewed and revised. Legal counsel was contacted on August 25, 2011 concerning revision of the policies and other matters.

Once Charleston became aware of the situation, the Administrator and the Assistant Administrator determined that changes in policy and additional training of staff was necessary. On Friday, August 26th, 2011 training was conducted for all staff including non-clinical staff during each shift (10am, 2pm, 4pm, and 11pm) concerning abuse prevention, abuse investigation, and abuse reporting. The training was conducted by key employees of the Facility including Marketing/PR Coordinator and Education Assistant; Assistant Administrator; and Co-Owner. Training session was overseen by the Administrator, s. Both and received training from concerning abuse prevention, abuse

investigation and abuse reporting. The Director of Nursing, _____ RN was then trained by _____ regarding allegation of abuse, reporting of abuse and investigation process regarding abuse allegations. _____ Assistant Administrator and _____

Administrator received training concerning abuse prevention, abuse investigation, and abuse reporting by legal counsel, _____ commencing August 25, 2011 and continuing through the present. Additional consultation was provided by _____ legal counsel concerning the situation with _____ the alleged perpetrator commencing August 12, 2011. At the completion of the training for the staff, a written quiz was taken by each staff member to verify the employee's comprehension of the material. This training was given to all 150 current employees. Training concerning abuse prevention, abuse investigation and abuse reporting will be given to any new employees of the Facility upon date of hire. Further, the Facility currently has one employee on medical leave. This employee will receive training concerning abuse prevention, abuse investigation and abuse reporting upon returning from medical leave. The employees successfully completed the quiz and the results were reviewed by Mr. Sparks, Administrator.

The Friday August 26y, 2011 training was given to all employees of the Facility even those without direct patient care duties. Charleston believes that any employee that may have contact with a resident and that all employees should be aware of the potential for abuse and should know how to report it in the event it is suspected or observed. As reported above. the training was conducted by key employees of Charleston including _____ Marketing/PR Coordinator and Education Assistant Administrator; and _____ Co-owner. Both _____ and _____ received training from _____ concerning abuse prevention, abuse investigation and abuse reporting. _____, Assistant Administrator and _____ Administrator received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel, _____. In addition, please note that Charleston works with legal counsel, _____ on a regular basis regarding regulatory compliance issues.

On Friday, August 26th, 2011 and August 30, 2011 each Department Head was specifically educated about the new policies and procedures emphasizing that potential abuse must be reported to both the Office of Inspector General and Adult Protective Services with the final results of an investigation communicated within five days. New tools have been developed for the use of Department Head staff. Verification of understanding of policies by Department Head staff was conducted by taking a quiz on the information received. The results of the quiz were reviewed by _____ Administrator and _____ Assistant Administrator, on the evening of Friday, August 26th, 2011. On Friday, August 26th, 2011 a checklist file was prepared and distributed to the department heads to assist them in following the correct procedures. Included in the Abuse Response Checklist is the Self-Reporting Form published by the Division of Health Care entitled "Long Term Care Facility-Self-Report Incident Form" along with the instructions. In addition, on the evening of August 30th, 2011 training regarding the emphasis of reporting suspected abuse was conducted by _____ Assistant Administrator, which was overseen and presented under the direction of _____

Administrator, [redacted] and [redacted] received training from legal counsel, [redacted] regarding suspected abuse reporting requirements.

The Abuse Policy-Supervision of Staff related to Abuse Potential was updated and revised concerning a supervisory employee's start to monitor and evaluate employees who may have a greater potential for abuse of a resident. This policy was revised on Thursday, August 25, 2011, immediately upon notification of the immediate jeopardy. This policy also instructs an employee to advise his or her supervisor if he or she is having problems dealing with stress-whether personal or work related. Both supervisors and employees are reminded of the confidential nature of these communications to the extent that resident safety is not compromised. Training about the revised and existing policies related to abuse was conducted by key employees

[redacted] Marketing/PR Coordinator and Education Assistant; [redacted] Assistant Administrator, and [redacted], Co-owner, which was approved and overseen by the Administrator, [redacted] and the Assistant Administrator, [redacted]. Both [redacted] and [redacted] received their training from [redacted] concerning abuse prevention, abuse investigation, and abuse reporting. [redacted] and [redacted] received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

The Abuse Policy and Screening Procedure for Potential Employees was amended and approved by [redacted], Administrator, on the Thursday evening, August 25th 2011, to include a screening process for administration to use when hiring new employees so that the potential for abuse is specifically considered in addition to the criminal record checks, abuse registry screens, license verification, state registration verification and reference checks. In Addition, all revision and amendment to policies were reviewed and approved by [redacted], Administrator. The training was conducted by key employees of Charleston including [redacted], Marketing/PR Coordinator and Education Assistant; [redacted], Assistant Administrator, and [redacted], Co-owner, who were overseen by the Administrator, Marlin Sparks. Both [redacted] and [redacted] received training from [redacted] Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

In addition please note that the Facility works on a continuous basis with [redacted] for training on regulatory compliance and is notified by [redacted] for training on regulatory compliance and is notified by Ms. Hinkle an any updates and/or changes to regulatory compliance issues.

The policies related to investigation were also reviewed and strengthened on the Thursday evening, August 25th, 2011 to make sure that investigations are carried out when reports of suspected abuse and abuse have been made as the investigation Protocol makes clear. These policies were reviewed and approved by [redacted] Administrator.

Continued training will be conducted on a bi-annual basis for all employees of Charleston Health Care Center. This training will include specifics regarding allegation of abuse, reporting of abuse, monitoring for signs of potential abuse and investigation procedures regarding alleged abuse. This training will be overseen and approved by [redacted]

the Administrator, In addition, any new hires will receive the above referenced training upon date of employment. The Director of Nursing will review compliance with training requirements and will report any and all findings to the quality assurance committee on a quarterly basis, which will monitor Facility compliance. Because all residents may be at risk for harm of ages if it exists changes and improvements were made to policies and procedures concerning abuse prevention, abuse investigation, and abuse reporting, on a system-wide basis and all 150 current staff members were educated about the policies on Friday, August 26th, 2011. The training was conducted by key employees of the Facility including Marketing/PR Coordinator, and Education Assistant; Assistant Administrator; and , Co-owner, who were overseen by Administrator. Both and I received training from concerning abuse prevention, abuse investigation and abuse reporting. and I received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Thursday evening, August 25, 2011, these policies include a specific provision that if a report of abuse is made that involves an employee, that employee will be reassigned from resident care to another job or suspended during the investigation. These charges were made to protect resident from retaliation or further acts of abuse.

As of Friday, August 26th, 2011, other policies have been implemented that are aimed at the protection of residents from abuse by employees. This includes training supervisory staff to recognize situation that may indicate stress on employees. Because individuals who are working under excessive emotional stress are more likely to be impatient they have a greater likelihood of committing abuse. The training was conducted by key employees of the Facility including , Marketing/PR Coordinator, , Co-owner, and , Assistant Administrator. Both and received training from Assistant Administrator concerning abuse prevention, abuse investigation and abuse reporting. received training concerning abuse prevention, abuse investigation and abuse reporting by legal counsel,

As of Friday August 26th, 2011, Charleston has initiated new procedures to ensure compliance by these important changes to policies and procedures. Education of staff however is vital to insuring that everyone understands their duty to report suspected abuse and to whom it is to be reported. The training will continue on abuse prevention, abuse investigation, and abuse reporting on a bi-annual basis overseen by Administrator. Also new staff will be thoroughly in-serviced by key employees of the Facility, overseen by Administrator, , on the policies and procedures pertaining to abuse, prevention, investigation, and reporting and importance of reporting requirement. In addition, the Facility and its administration believes that by incorporating the duty to be vigilant about employee stressors into the policies for supervisory employees and employees that staff will be more sensitive to situations that make staff more susceptible to acting in an abusive manner.

In addition, residents will be monitored on a daily basis by the treatment nurse for any skin changes or signs of potential abuse. Any suspected or actual abuse discovered by the treatment nurse will be reported to the charge nurse, who in turn is required to report the findings to the Director on Nursing, _____, RN, who then reports immediately to _____ Assistant Administrator, and _____, Administrator. _____, Assistant Administrator will then notify any and all appropriate State Agencies.

The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained. As of Thursday evening, August 25th, 2011, the Facility revised relevant policies and as of Friday, August 26th, 2011 has educated staff about those policies. The training was conducted by key employees of the Facility including _____ Marketing/PR Coordinator and Education Assistant, _____ Assistant Administrator; and _____ Co-owner under the supervision and direction of the Administrator _____ Both _____ and _____ received training for _____ concerning abuse prevention abuse investigation and abuse reporting. _____ received training concerning abuse prevention abuse investigation and abuse reporting by legal counsel _____. In addition, by creating the new tool for Department Heads, which walks the individual through the steps that should be taken when abuse is suspected or reported, the Facility is confident that its solution will be sustained. In addition all reports of suspected abuse are to be immediately reported and given to the charge nurse. The charge nurse will then immediately report the suspected abuse to the Director of Nursing and will record the allegation in the 24-hour nurses' report. The Director of Nursing and _____ Assistant Administrator, will review the 24-hour nurses' report on a daily basis and will report any alleged abuse in compliance with any and all regulatory requirement to _____ Administrator, and any and all state agencies necessary. This will insure that communication of suspected abuse as well as abuse is address and monitored by Facility Administration.

When abuse is suspected or discovered, the Administrator and the Assistant Administrator shall monitor the situation according to Facility policies to assure that any employee suspected to have perpetrated abuse will be suspended or reassigned from resident care duties until a full investigation has been completed and a determination reached, that all reports have been made, and that the situation has been appropriately documented. Additional monitoring will be carried out by the Quality Assurance Committee that receives all reports of suspected or actual abuse.

Additional in-service training was held on Friday September 16th, 2011, & Tuesday September 20th, 2011 with key department heads and licensed nurses. Training included abuse, abuse reporting, and abuse documentation. _____ Assistant Administrator presented training under the direction of _____ Administrator. _____ Administrator, and _____ Assistant Administrator have received continued education for legal counsel

A book of allegations and log of all abuse, abuse reporting, abuse documentation, abuse investigation if to be kept in the Administrator/Assistant Administrator's office. The book will be used for compliance, quality assurance, and record keeping. This book was started September 2, 2011.

The Facility was in substantial compliance on August 31, 2011.

The following corrective actions were immediately taken to address the deficient practices:

Criteria #1 - The plan of correction fails to address corrective actions taken for residents identified in the deficient practice.

Please find attached as Exhibit 1, updated policies addressing abuse allegations.

Resident 1:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #1 did not suffer any abuse or harm either mental or physical. The following specific actions were accomplished for Resident #1:

- Head to toe skin assessment of Resident #1 was completed on 8/12/11.
- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse, or harm substantiated for Resident #1.
- Interview with Resident #1 was conducted on 8/12/11.
- Resident #1's family was notified of the alleged abuse and interviewed on 8/13/11. It is interesting that Resident #1's family was supportive of the alleged perpetrator, thought that he worked well with Resident #1, did not confirm any abusive behavior on the part of the employee, and did not note any physical or mental indications of abuse for Resident #1.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #1 based on the report of alleged abuse on 8/15/11 and determined that Resident #1 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in

patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.

- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. Initial training of staff was completed by 8/26/11 with additional training in September. In October, policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization and restatement of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.
- Additional education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.
- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented where allegations of abuse are recorded. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Education of Key Employees that include Administrator, DON, assistant director of nursing, social work director, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11 and again on 9/16/11, and 9/20/11.

- Random interviews of Residents were conducted to identify if any other potential abuse victims existed on 8/30/11.
- Procedures involving the proper recordkeeping for background checks so that only qualified employees with no reported instance of abuse are hired were reviewed. The Facility performs background checks for all staff, not just clinical staff. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures.
- The nursing staff was also educated about their respective duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse, etc. Specific training took place on 8/26/11, 9/16/11 and 9/20/11. Ongoing training is also provided.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.
- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes. Exhibit 3.

Resident 2:

Corrective actions were immediately taken to address the deficient practice identified by state surveyors. It is important to note that while corrective action was taken, the investigation of alleged abuse indicated that Resident #2 did not suffer any abuse either mental or physical. The following specific actions were accomplished for Resident #2:

- Head to toe skin assessment of Resident #1 was completed on 7/22/11 and on 8/17/11.

- A comprehensive investigation was initiated on 8/12/11 and completed on 8/17/11 with no mental, physical, other abuse or harm substantiated for Resident #2. Resident #2 has mental impairments that cause him to make statements that are imagined and without basis. It was determined that Resident #2's statements were not accurate.
- Interview with Resident #2 was conducted on 8/12/11.
- Resident #2's allegations of abuse occurred in July. At the time, staff notified Resident #2's family about his allegations. Later in July the DON personally communicated with Resident #2's family about his allegations. The family as well as Facility staff did not find the allegations to be true as a result of Resident #2's mental status and frequent statements that did not reflect reality. While Resident #2 did name the same CNA his statements were found to be untrue.
- Accused perpetrator was terminated from employment on 8/12/11.
- The Facility's medical director assessed Resident #2 based on the report of alleged abuse on 8/15/11 and determined that Resident #2 had not suffered mental or physical injury.
- Pursuant to Facility procedures, the charge nurse for each shift has the responsibility of completing a report about all important issues that affect patient care including allegations of abuse, change of abuse, change in patient condition, etc. The DON has the daily responsibility of reviewing all the charge nurse reports to complete a form (24-Hour Report) that documents the important changes that occur during each 24 hour period. The DON is responsible for reviewing all charge nurse reports for the weekend on Mondays to complete the 24-Hour Report. The 24-Hour Report includes a carbon copy that is distributed to the Administrator and/or the Assistant Administrator. The 24-Hour Report is an important and effective tool to communicate information between the clinical staff and the Administration. Exhibit 2.
- Pursuant to CMS requirements, patients' treating physicians were notified in writing of the substandard of care on 9/26/11.
- The Facility's Abuse Policies and Procedures were revised, updated and reorganized. The first review and revision of policies was completed on 8/25/11. The policies were then revised and reorganized to make them easier to read and understand. No substantive changes were made other than to clarify the monitoring mechanisms. The reorganization of the Facility's Abuse Policies and Procedures was accomplished by 10/12/11.
- Intense training of staff concerning the Facility's revised Abuse Policies

and Procedures was conducted on 8/26/2011. Each staff member was required to successfully complete a quiz to verify knowledge about the new policies and procedures. Results were verified by the Administration. Staff was again trained in September. When the policies were reorganized and restated in October, staff was again trained.

- Additional Education of "Key Employees" (all Department Heads, MDS Coordinator, Social Work Director, Business Office, Director of Physical Plant, and Laundry and Housekeeping Supervisor) concerning their specific duties regarding all aspects of the Facility's response to allegations of abuse including the investigating, reporting, responding, and monitoring for compliance established by Facility policies and procedures, was conducted on 8/31/11, 9/16/11 and 9/20/11; and in October.
- To aid and assist in the recording and communication of allegations of abuse, a notebook procedure was implemented to record allegations of abuse. Key Employees with responsibilities for the investigation and reporting of allegations of abuse were educated about the process and their respective duties using the notebook. Key employees include Administrator, director of nursing, assistant director of nursing, social work, assistant Administrator as well as the entire nursing staff including LPN's was completed on 8/25/11.
- Random Interviews of Residents were conducted to identify any other potential abuse victims existed on 8/30/11.
- Proper record check/keeping to identify safe employees upon hire. Upon hire, all staff will be trained on the Abuse Policies and Procedures as well as other Facility policies and procedures. The nursing staff was also educated about their duties related to allegations of abuse that include the duty to report and document allegations of abuse as well as how to report and respond to allegations of abuse. etc.
- Monitoring of residents to determine if allegations of abuse have been reported will be performed by the treatment nurse became effective 8/12/11.
- In addition, on 8/10/11 Charleston entered an agreement with Park View Psychiatric Services ("Park View"). This clinical service will provide psychiatric treatment to residents with psychiatric diagnoses and review treatment and care plans of residents. Park View will review and assist in the development and refinement where necessary of patient care policies; assume responsibility for the treatment of patients with psychiatric diagnosis; provide 24 hour coverage for calls including timely response to recommendations from other health care professionals involved in

residents' care; and coordinate care for patients with psychiatric diagnoses. Park View will designate a Psychiatrist and/or Advanced Registered Nurse Practitioner to monitor and treat patients with psychiatric diagnoses; participate in assessment and care planning process in accordance with established procedures; review residents' medication and other treatment orders at time of visit; and complete all patient records with progress notes.

Criteria # 4 - The plan of correction failed to include specifics/details related to monitoring.

Charleston will monitor its performance on an on-going basis to assure that its Facility Policies and Procedures are implemented in a timely and effective manner. The treatment nurse has been assigned the responsibility of monitoring each shift, (24 hours per day, 7 days per week) for any reports of allegations of abuse. When reported, the treatment nurse is to initiate procedures in a manner consistent with Facility policies and procedures.

- The Facility has implemented a process that includes shared staff responsibility for timely reporting, investigating, addressing, and monitoring allegations of abuse. By assigning the treatment nurse, the charge nurse, and the DON to report allegations of abuse, effective compliance will be maintained. Date: 9/21/11.
- All Facility staff has been educated about the policies and procedures to be followed when abuse is discovered/reported or allegations of abuse are made. Dates: 8/25/11, 9/16/11, and 9/20/11.
- All Certified Nursing Assistants ("CNA") have the duty to report any allegations, symptoms, or signs of abuse to charge nurse immediately upon discovery; staff has been extensively educated about this duty. Dates: 8/25/11, 9/16/11, and 9/20/11.
- Nursing staff assigned the duties of treatment nurse is required to undertake a specific review of patients and staff for reports of abuse or potential abuse and is to report the same to charge nurse each shift.
- The Charge Nurse has the duty to report allegations of abuse to DON during business hours and if allegations are reported after business hours; the charge nurse is to report the allegations to the Administrator or assistant Administrator when received after business hours.
- The Administrator is to follow up within 48 hours of any report of alleged abuse to determine and verify all policies and procedures regarding alleged abuse were followed and that the investigation has been completed;

- Clinical staff shall assess and identify residents who may have the potential for abusive behavior and this shall be addressed through care planning and monitoring of residents with needs and behaviors that may lead to conflict or neglect.
- Any residents identified as having the potential for abusive behavior through care planning and monitoring will be reported to charge nurse each shift; the charge nurse will then report this information to the Administrator.
- To assure further compliance with monitoring, the Facility has arranged for qualified psychiatrist and other mental health professionals to help the staff manage difficult or aggressive residents.
- Random head to toe examinations, in addition to scheduled skin assessments for residents, will be conducted on a monthly basis by nursing staff. Any signs of abuse will be immediately reported to the charge nurse on duty, which will immediately report the findings to the administration.
- Continuous monitoring will all occur through interviews with visitors, family, volunteers, that will be conducted monthly.
- DON and Assistant Administrator and/or Administrator will meet five times a week specifically to discuss whether any allegations of abuse have been reported or any signs of abuse noted by staff for any resident.
- Daily meeting of the key employees (that include Department Heads, Administrator, Assistance Administrator, MDS Coordinator, DON, Activities Director, Social Services, Dietary, Restorative Nurse, Office Manager and Housekeeping and Laundry) will occur to address concerns and identify problems including any reports of abuse or alleged abuse.
- Monitoring and review of abuse allegations and investigations has been added to Quality Assurance Committee's duties; the Administrator will designate a clinical staff member to monitor and supervise each allegation of abuse that is received prior to the QA meeting to determine whether Facility procedures and policies have been followed in a timely manner.
- Administrator or his delegate has the responsibility to perform and/or supervise the investigation, to make proper and timely reports, and to document satisfactory resolution of abuse allegations. To facilitate timely supervision, a log shall be kept in the Administrator's office that records every allegation of abuse and a tool to determine that Facility policies and procedures have been followed in a timely manner. This book will contain all information IE, incident report, statements, nurses notes, 24 report, face

sheet of resident, MDS, self-report to OIG, fax confirmation, final report, receipt of report to Adult Protective Services along with a log indicating when the action has been taken;

- The Administrator and Assistant Administrator are responsible for reviewing the log book to determine and monitor compliance with regulations and Facility Policies and Procedures. In addition, the Administrator and Assistant Administrator are responsible for making all reports of allegations of abuse and findings, and for completing the investigation within 5 days with the help of key employees. The Administrator shall report the results of all investigations of abuse in timely manner as required by Facility policy and procedure as well as state law.

Criteria #5 – The completion date is prior to the survey exit date.

To address the concerns of the Office of Inspector General, the Facility has revised the Plan of Corrections as previously submitted. Although the Plan of Corrections has been supplemented, the Facility achieved substantial compliance as of 8/31/11. Even though Charleston has taken additional steps including reorganization and restating of abuse policies and procedures on 10/12/11. The staff was educated on the reorganized and restated policies with written copies of the new policies distributed on 10/13/11. The survey was completed on 9/1/11 and the immediate jeopardy was removed on 8/31/11 even though the original Plan of Corrections has been supplemented, Charleston achieved substantial compliance on 8/31/11.