

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

PRINTED: 11/25/2014
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

DEC - 3 2014

Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185871	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2014
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NAME OF PROVIDER OR SUPPLIER PAUL E PATTON EASTERN KY VETERANS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 VETERANS DRIVE HAZARD, KY 41701
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F 000 INITIAL COMMENTS

An abbreviated standard survey (KY22399, KY22453) was conducted on 11/10/14. KY22453 was unsubstantiated with no deficient practice identified. KY22399 was substantiated with deficient practice identified at "D" level.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=D 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, 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).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

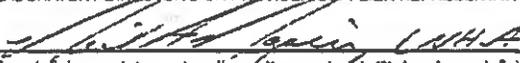
The results of all investigations must be reported to the administrator or his designated

F 000 Response to F 225. The following policy has been revised and implemented so that our facility can be assured that proper and thorough investigations are conducted.

F 225 Facility policy 6.08 titled, "Abuse Prevention Program," has been revised and added a procedure that ensures investigations are conducted properly and thorough. Reviewed last 6 months of investigations and no errors in the investigation process occurred. Form "EKVC Abuse Investigation Internal Checklist" has been created and implemented for use in investigations. This sheet will be used internally to assure that all investigative steps are taken and followed by checking off steps as they are completed and being submitted to the Administrator or Assistant Administrator within five days for final approval and submission.

Additionally all staff not on leave were trained on the "Abuse Prevention Program" policy specifically relating to resident confinement by November the 5th, 2014. Furthermore, all residents that smoke have been interviewed by Social Services and it was found that this was an isolated incident and has not occurred before.

Final date of corrections occurred on 12/3/2014.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/3/2014
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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 225	<p>Continued From page 1</p> <p>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 observation, interview, record review, and review of the facility's investigation and policy and procedures, it was determined the facility's investigation failed to include resident interviews related to an allegation of abuse for one (1) of three (3) sampled residents (Resident #4). A review of the facility investigation revealed a State Registered Nurse Aide (SRNA) had locked Resident #4 in the "smoke room" after the resident did not exit the room when asked. A review of the facility investigation revealed Resident #4 was interviewed about the incident; however, the facility had failed to interview other residents who utilize the smoke room to determine if they had witnessed or been affected by similar violations.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Abuse Prevention Program," revision date 07/16/12, revealed involuntary seclusion is defined as separation of a resident from other residents against the resident's will. The initial investigation should include interviews of witnesses including but not limited to the following: assigned caregiver, caregivers in the immediate area, potential witnesses such as visitors, family, roommates, and the alleged perpetrator.</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>A review of the medical record for Resident #4 revealed the facility re-admitted the resident on 11/27/13 with diagnoses including Post Traumatic Stress Disorder (PTSD), Depression, and Dementia. A review of the resident's significant change Minimum Data Set (MDS) assessment dated 07/24/14, revealed the resident to be assessed to have a Brief Interview for Mental Status (BIMS) score of 10 which revealed the resident is moderately cognitively impaired.</p> <p>A review of the five-day final report of the facility investigation, dated 10/28/14, revealed the facility Social Worker (SW) observed SRNA #1 standing outside the facility smoke room by the pool table on 10/21/14. The SRNA informed the SW he/she was unable to get Resident #4 to leave the smoke room. Continued review of the investigation revealed SRNA #1 informed the SW that the SRNA had told Resident #1 if the resident did not come out of the smoke room the SRNA was going to lock the door. The SW then informed the SRNA she would get Resident #4 to come out. Further review of the investigation revealed when the SW went to the smoke room door, she observed Resident #4 inside the smoke room, and the door to the smoke room was locked. Review of the investigation revealed the SW informed SRNA #1 she should never lock a resident in a room or threaten to lock a resident in a room. SRNA #1 told the SW she had called the resident's bluff and locked the door because the resident would not come out of the smoke room. Further review of the investigation revealed Resident #4 did not appear to be in any distress when the smoke room door was opened. A review of the investigation revealed Resident #4 and staff that worked with the resident were</p>	F 225	

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F 225	<p>Continued From page 3</p> <p>interviewed; however, the investigation had no documented evidence that other residents that smoke were interviewed as part of the investigation. Further review of the investigation revealed SRNA #1 was immediately removed from the floor and resident care.</p> <p>Interview on 11/10/14 at 1:35 PM with Resident #4 revealed the only problem the resident had in the smoke room was when a worker locked the resident in there one day for a few minutes. The resident denied that he/she was "bothered" by the incident because the resident was able to finish his/her cigarette.</p> <p>A review of a witness statement written by SRNA #1 on 10/22/14 revealed on 10/21/14 at approximately 1:30 PM, SRNA #1 had informed all residents the smoke break was over and the residents needed to exit the smoke room. All of the residents had left the room except for Resident #4. The witness statement further revealed SRNA #1 informed the resident several times the smoke break was over and the resident needed to leave the smoke room but the resident continued to sit in the smoke room. SRNA #1 revealed she stated to Resident #4, "You better come out or I will lock the door," and Resident #4 stated to the SRNA, "You won't do it." The witness statement revealed SRNA #1 left the smoke room, locked the door, and assisted another resident in a wheelchair around the corner. Further review of the witness statement revealed SRNA #1 had no intentions of leaving the resident in the smoke room and did not mean any harm to the resident.</p> <p>Interview on 11/10/14 at 3:45 PM with the SW revealed she was walking toward the smoke</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>room and observed SRNA #1 standing by the pool table. The SRNA informed the SW he/she was unable to get Resident #4 to come out of the smoke room. The interview further revealed SRNA #1 informed the SW that the SRNA had told Resident #4 if he/she did not come out of the smoke room the SRNA was going to lock the door. The SW informed SRNA #1 she would get the resident to come out. Continued interview revealed when the SW went to the smoke room door she observed Resident #4 inside the smoke room and the door to the room was locked. The SW revealed the smoke room door was unlocked by SRNA #1 and the resident came out of the smoke room and did not appear to be in any distress. The interview further revealed the SW informed SRNA #1 that staff should never lock or threaten to lock a resident in a room. Continued interview revealed the SW immediately reported the incident to the Director of Nursing (DON) and the SRNA was removed from the floor. The interview revealed the SW conducted the investigation of the incident and denied interviewing other residents related to the allegation because the allegation obviously happened and the SRNA admitted to locking the door of the smoke room.</p> <p>Interviews on 11/10/14 at 4:55 PM with the Administrator, DON, and Assistant Administrator revealed the administrative staff reviewed all investigations and did not find a problem with the investigation related to Resident #4. The interview further revealed the administrative staff felt the investigation was "an open and shut case" because SRNA #1 had reported locking Resident #4 in the smoke room. The administrative staff acknowledged that other residents that use the smoke room should have been interviewed as</p>	F 225		

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