

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

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05/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 40363 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	INITIAL COMMENTS	F 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings.	
F 225 SS=D	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, 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 representative and to other officials in accordance	F 225	This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents. F 225 483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT/ALLEGATIONS/INDIVIDUALS It is the policy of this facility that all residents are protected from abuse, neglect and mistreatment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Debrah F. [Signature]* TITLE: *Administrator* (X8) DATE: *6-11-12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>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, facility policy review, facility in-service review and review of facility investigations, it was determined the facility failed to ensure residents were protected from abuse and failed to immediately report all allegations of abuse to the administrator for one (1) of three (3) sampled residents (Resident #1). On 04/30/12, Certified Nursing Assistant (CNA) #10 reported to Registered Nurse (RN) #1 that CNA #2 and CNA #11 had physically abused Resident #1. However, RN #1 failed to immediately report the allegation to the facility's Administrator, Director of Nursing (DON), or the state survey and certification agency. RN #1 also failed to ensure an investigation of the allegation was initiated, failed to ensure residents were protected from abuse after receipt of the allegation, and permitted CNAs # 11 and #2 to continue to provide direct care to residents of the facility after receipt of the allegation.</p> <p>The findings include:</p> <p>A review of the facility abuse policy, not dated, revealed when an incident or suspected incident of abuse was reported, the investigation was required to begin immediately by a member of management. It was the policy of the facility that all personnel promptly report any incident or</p>	F 225	<p>It is the policy of this facility that (1) all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the administrator of the facility and other officials in accordance with State Law including the State survey and certification agency, (2) all alleged violations are thoroughly investigated and (3) protective measures should be taken immediately if an allegation of abuse, mistreatment or neglect is reported.</p> <p>This is evidenced by the following:</p> <p>Resident #1</p> <ol style="list-style-type: none"> The DON, Mary Arms was notified by phone on 4/30/2012 at approximately 8:40 PM of an allegation of abuse related to resident #1. She (Mary Arms, DON) notified the facility Administrator, Deborah Fitzpatrick and the Assistant Administrator Emily Jones Gray. Mary Arms and Emily Jones Gray went to the facility and started the investigation immediately. <p>Resident #1 was interviewed and assessed for injury on 4/30/2012 by Mary Arms, DON and Emily Jones Gray, Assistant Administrator.</p> <p>All staff working during the evening of 4/30/2012 after the allegation was reported were inserviced by Mary Arms, DON and Crystal Little, RN on abuse</p>		

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F 225	<p>Continued From page 2</p> <p>suspected incident of resident abuse to the administrator or DON. According to the policy, employees of the facility that were accused of resident abuse were required to be suspended immediately pending an investigation or until the results of the investigation had been reviewed by the administrator.</p> <p>A review of the facility investigation, not dated, revealed RN #1 was conducting a medication pass on 04/30/12, at approximately 6:10 PM, when she went into Resident #1's room and observed the resident had vomited and asked CNA #2 and CNA #11 to provide care for Resident #1. Documentation in the report revealed CNA #10 asked RN #1 to go to Resident #1's room and reported she (CNA #10) had witnessed CNA #2 "dump" a pan of water over Resident #1's head. According to the report, RN #1 went into Resident #1's room and observed the resident had been positioned onto the side. RN #1 also noted CNA #2 was changing the resident's bed sheets. Continued review of the investigation report revealed RN #1 "looked" the resident over and did not see any injury. According the investigation, RN #1 stated she did not see anything "out of the way" when she observed Resident #1 and therefore did not report the allegation. Further review of the facility investigation revealed a written statement by CNA #2, not dated, which stated Resident #1 was covered in stool, so the CNA took a pan of water and poured it over the resident attempting to get the resident clean. CNA #2's written statement revealed, "I don't think what I did was over the top or bad because resident needed clean and [she/he] looked a lot better." A review of a written statement by CNA #11, not dated, revealed</p>	F 225	<p>prevention and facility policy. See attachment #1.</p> <p>The two nurse aides implicated in the allegation had already left the building and were scheduled to return to work on 5/1/2012. Mary Arms, DON came in on 5/1/2012 before their shift started and terminated the two nurse aides. See attachment #2.</p> <p>On 5/1/2012 Mary Arms, DON and Emily Jones Gray, Assistant Administrator reviewed the care plan of Resident #1 with no changes.</p> <p>On 5/1/2012 Mary Arms, DON notified the family and physician of Resident #1 of the allegation.</p> <p>On 5/1/2012 Mary Arms, DON notified the facility Medical Director Dr. Charles Hardin of the allegation and actions taken (to this point) by the facility to protect residents.</p> <p>The initial report (05-01-2012) of the allegation as well as the results (05-07-2012) of the investigation were both sent to the OIG as required by regulation and facility policy.</p> <p>Adult Protective Services was contacted via phone by Mary Arms, DON on 05-01-2012 and the report</p>

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F 225	<p>Continued From page 3</p> <p>Resident #1 had vomited and CNA #11 and CNA #2 went in to clean the resident and CNA #2 took the whole pan of water and poured it on the resident and it splashed on the resident's face. Continued review of CNA #11's statement revealed she, CNA #11, did not get rough with the resident but she was "holding the resident down" because the resident was "kicking so hard" the resident was "about to come out of bed."</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 07/28/09. The resident had diagnoses to include Huntington's Chorea, Depressive Disorder, Dementia with behaviors, and Stress Reaction. A review of Resident #1's annual Minimum Data Set (MDS) dated 12/16/11, revealed the facility assessed the resident to have cognitive skills that were severely impaired, required extensive assistance of two staff members for bed mobility, extensive assistance of one for dressing, and total dependence of two for bathing.</p> <p>Due to Resident #1's impaired cognition, an interview with the resident was not conducted.</p> <p>An interview with CNA #10 on 05/15/12, at 5:18 PM, revealed on 04/30/12, Resident #1 had vomited on him/herself and CNA #10 had requested assistance from CNA #2 and CNA #11 to clean the resident. CNA #10 stated she undressed the resident, removed the sheets from the resident's bed, and had a pan of water to cleanse the resident. According to CNA #10, CNA #2 and CNA #11 entered Resident #1's room, CNA #11 "grabbed another rag, soaped it up and rubbed it down [her/his] face" wiping the rag into the resident's mouth. CNA #10 further</p>	F 225	<p>was made to the Centralized Intake Team.</p> <p>The nurse who failed to report the allegation of abuse to facility administration was inserviced on 05-01-2012 regarding the Facility Abuse Prevention Policy specifically reporting and resident protection by Chantry Purcell, LPN, Staff Development. See attachment #3.</p> <p>The nurse who failed to report the allegation of abuse was given a disciplinary warning on 06-10-2012 by Mary Arms, Director of Nursing. See attachment #4.</p> <p>2. On 5/1/2012 Resident interviews were conducted by Kathy Meadows, Social Services and Misty Pennington, Social Services to determine if other residents had been affected. Thirty (30) residents were able to participate in the interviews. No other residents were identified as being affected.</p> <p>Staff (other nurse aides and nurses who had worked with the two nurse aides involved in the allegation) were interviewed by Mary Arms, DON and Emily Jones Gray, Assistant Administrator to determine if other residents had been affected. No other residents were identified as being affected.</p>		

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F 225	<p>Continued From page 4</p> <p>stated CNA #2 took the pan of water, "dumped" the water onto Resident #1, and as a result, the water splashed in the resident's face. CNA #10 stated Resident #1 started "crying and screaming" and "hollering." Further interview revealed CNA #8 walked into the room to ask if they needed help. CNA #10 stated when CNA #8 walked in CNA #2 and CNA #11 were rolling the resident over in bed and caused the resident's head and knee to hit the bed rail. CNA #10 stated Resident #1 would attempt to pull away from CNA #11 and CNA #11 would "pull harder." CNA #10 stated during this time CNA #2 and CNA #11 were laughing at the resident. CNA #10 further stated she reported what she had witnessed to RN #1 and RN #1 told the CNA she would go talk to them. CNA #10 stated RN #1 acted "like no big deal." According to CNA #10, when RN #2 came into work at shift change, she reported the incident to RN #2 and RN #2 reported the incident to the DON.</p> <p>An interview with CNA #2 on 05/15/12, at 12:23 PM, revealed she and CNA #11 were on break when CNA #10 informed them Resident #1 needed to be cleaned. According to CNA #2, when she and CNA #11 entered the resident's room, CNA #10 had already started taking the sheets off the bed. CNA #2 further stated they undressed the resident and she, CNA #2, poured the water over the resident due to the resident having stool all over the body. CNA #2 further stated they "soaked [her/him] down, got [her/him] cleaned up." The CNA further stated CNA #10 left the room and RN #1 came in and told CNA #2 and CNA #11 she had to do an investigation; she examined the resident, watched the CNAs for a brief time, and left the room. CNA #2 stated CNA</p>	F 225	<p>Copies of staff statements were sent as part of the final investigation report to OIG.</p> <p>3. Inservices were held on 4/30/12, 5/01/12, 5/02/12 for all nursing staff by Mary Arms, DON, Chantity Purcell, LPN Staff Development and Crystal Little, RN concerning the Facility Abuse Prevention Policy. See attachment #5.</p> <p>On 6/6/2012 Mary Arms, DON inserviced Licensed Nurses again on the Facility Abuse Prevention Policy. This inservice covered the abuse prevention policy and specifically instructed nurses on the steps they should take when an allegation of abuse is reported to them and to remove the alleged perpetrator from the facility. See attachment #6.</p> <p>All other facility staff (dietary, laundry, housekeeping, maintenance, administrative and therapy staff) will be inserviced on the Facility Abuse Prevention Policy and reporting.</p> <p>The Facility Abuse Prevention Policy was reviewed by Deborah Fitzpatrick, Administrator, Mary Arms, DON, Emily Jones Gray, Assistant Administrator and the Medical Director, Dr. Charles Hardin with no changes to the</p>		

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F 225	<p>Continued From page 5</p> <p>#11 "held" the resident during the bath due to the resident being combative. Further interview with CNA #2 revealed Resident #1 had a scratch above the eye, and stated the scratch had been above the resident's eye "all day."</p> <p>A review of CNA #2's personnel file revealed the facility had conducted a criminal record check prior to the CNA's employment and there were no findings reported. A review of facility in-services revealed CNA #2 was in-serviced on the facility abuse policy and resident rights on 04/16/12 and 04/26/12.</p> <p>An interview with CNA #8 on 05/15/12, at 3:21 PM, revealed the CNA was in the hallway and heard Resident #1 "scream." CNA #8 stated she went into the room and observed CNA #2 and CNA #11 in the resident's room. CNA #8 stated CNA #2 was drying the bed with towels and CNA #11 pulled Resident #1 over in the bed a little too "rough." Further interview revealed RN #1 asked CNA #8 if she had seen anything while she was in Resident #1's room and CNA #8 informed RN #1 she had observed CNA #11 pull the resident in the bed too "rough." CNA #8 stated she was later interviewed by the DON and Assistant Administrator and informed them both the resident had been pulled too "rough" by CNA #11.</p> <p>An interview with RN #1 revealed on 04/30/12, she was passing medication next to Resident #1's room and smelled an odor; when she entered Resident #1's room she observed the resident had vomited on him/herself. RN #1 stated she informed CNA #2 and CNA #11 that the resident needed to be cleaned. RN #1 further stated when she finished passing medications</p>	F 225	<p>policy on 05-01-2012. The policy was signed by the Medical Director. See attachment #7.</p> <p>The Facility Abuse Prevention Policy was added to the Nursing Policy book which is located at each nursing station and is available for all staff to review.</p> <p>Specific instructions for reporting abuse/neglect according to the Facility Abuse Prevention Policy was added to the new licensed nurse employee orientation folder and will be conducted by Donna Wells, Human Resources. See attachment #8.</p> <p>4. Random interviews of 12 residents will be conducted monthly by Kathy Meadows, Social Services and Misty Pennington, Social Services for a minimum of 6 months. This will be reported quarterly through CQI by Emily Jones Gray, Assistant Administrator.</p> <p>A form was developed to use during resident interviews for CQI purposes. See attachment #9.</p> <p>Random interviews of 12 employees will be conducted monthly by Mary Arms, DON, Anna Caldwell, RN, Christy Moore, RN and Emily Jones Gray.</p>	

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F 225	<p>Continued From page 6</p> <p>CNA #10 informed her that CNA #11 and CNA #2 had dumped a pan of water over Resident #1's head and requested RN #1 to go to the resident's room. RN #1 stated she immediately went to Resident #1's room and observed CNA #11 holding the resident while CNA #2 was putting sheets on the resident's bed. RN #1 further stated she observed the resident's skin and did not see any "markings" on the skin. Further interview revealed CNA #2 and CNA #11 had asked the nurse what was going and the nurse informed them it was alleged they had dumped water on the resident's head. RN #1 stated she did not see anything to lead her to believe the allegation was true; therefore, she left the room without removing the two staff members, investigating the incident, or reporting the allegation to Administration. RN #1 stated she was not aware it was her responsibility to protect the residents by removing alleged perpetrators, nor was she aware it was her responsibility to report allegations of abuse to Administration.</p> <p>A review of RN #1's personnel file revealed the facility had conducted a criminal record check prior to the RN's employment and there were no findings reported. A review of facility in-services revealed RN #1 was in-serviced on the facility abuse policy and resident rights on 04/26/12.</p> <p>Numerous attempts were made to interview CNA #11 with no success. However, a review of CNA #11's personnel file revealed the facility had conducted a criminal record check prior to the CNA's employment and there were no findings reported. A review of facility in-services revealed CNA #11 was in-serviced on the facility abuse policy and resident rights on 04/26/12.</p>	F 225	<p>Assistant Administrator for a minimum of 6 months. The results will be reported quarterly through CQI by Emily Jones Gray, Assistant Administrator.</p> <p>A form was developed to use during employee interviews for CQI purposes. See attachment #10.</p> <p>A statement was added to the interview form informing the interviewer to report any allegations of abuse/mistreatment to the administrator/designee immediately.</p> <p>The Medical Director, Dr. Charles Hardin will be informed during the CQI meeting of the interview results and any measures implemented as a result.</p> <p>This Plan of Correction was sent to Dr. Charles Hardin, Medical Director for review and approval on 06-11-2012.</p> <p>5. Date of Completion 06/15/2012</p>		

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F 225	Continued From page 7 An interview with the DON on 05/15/12, at 4:50 PM, revealed on 04/30/12 at approximately 7:40 PM, she received a call from RN #2 and was informed of the abuse allegation. According to the DON, she spoke to CNA #10 by telephone at that same time and the CNA informed her CNA #2 had poured a pan of water over Resident #1 during a bath and also reported CNA #11 had held the resident's leg and arm "to rough." The DON stated CNA #10 further informed her CNA #2 and CNA #11 were "laughing at the resident." The DON stated she immediately went to the facility and initiated an investigation. A skin assessment of Resident #1 revealed a scratch over the resident's left eye and scratches on the left knee that looked "fresh." The DON stated she interviewed staff still present at the facility, and stated CNA #2 and CNA #11's shift had ended and they had already left the facility. The DON stated the next morning CNA #2 and CNA #11 were terminated from the facility prior to providing direct care. An interview with the Assistant Administrator on 05/15/12, at 4:50 PM, revealed staff received in-services at least four times a year and were instructed on the facility's abuse policy, to report allegations of abuse, to protect the residents, and to notify Administration of all allegations of abuse.	F 225			