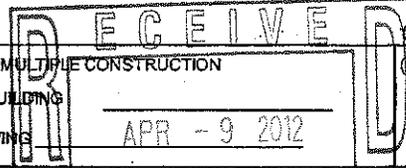


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/15/2012
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NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DEBICKSON LANE Health Care STANTON, KY 40380 - 0000
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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
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An abbreviated standard survey (KY17904, KY18030) was conducted on 03/15/12. KY17904 was unsubstantiated with no deficient practice identified. KY18030 was substantiated with deficient practice identified at "D" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</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</p>	F 225	<p>F 225 Corrective Actions for Targeted Resident(s): Resident's #1 and #2 had complete head to toe skin assessment performed and were observed for behaviors and pain on 03/14/12, and no injuries, behaviors or pain were noted. CNA's #1, #2, #3 and the DOM were all discharged for their involvement and failure to immediately report an allegation of abuse and neglect. CNA #8 received disciplinary action for his late reporting of an allegation of neglect and or abuse.</p> <p>Identification of Other Residents with Potential to Be Affected: All residents of the facility have the potential to be affected. The Administrator reviewed all Accident and Incidents reports and Investigation 90 days prior to the investigation of 03/15/12. There was no evidence of</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 4/4/12

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>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 a review of facility policies, the facility failed to ensure alleged violations involving neglect were reported immediately to the Administrator of the facility for two of three sampled residents (Residents #1 and #2). Certified Nurse Aides (CNAs) #1, #2, and #3 stated on numerous occasions (dates unknown) they observed Resident #1 and Resident #2 at the lunch meal, wearing the clothing that had become soiled at the breakfast meal, and suspected CNA #4 neglected the residents' care. CNA #2 reported her concerns related to CNA #4 to the Director of Maintenance Services (DOM), however, interviews revealed the CNAs and the DOM failed to report their concerns immediately to the Administrator.</p> <p>The findings include: A review of the Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property policy (revised February 2011) revealed staff was required to report alleged violations to the Administrator and Director of Nursing (DON)/designee immediately. According to the policy, "immediately" meant as soon as possible</p>	F 225	<p>an alleged violation involving neglect and or abuse not being reported to the Administrator and or Director of Nursing immediately or not exceeding 24 hours after the discovery of an incident.</p> <p>Systemic Changes: All Nursing line staff, and licensed staff, as well as Department Heads and Administration of the facility will be re-educated (in-serviced) regarding the established facility policy and procedure on Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property by 05/01/2012. This re-education is being conducted by the Administrator, Director of Nursing and or the Education Training Director. The in-service will place special emphasis on:</p>		

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F 225	<p>Continued From page 2 but was not to exceed 24 hours after discovery of the incident.</p> <p>1. A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 04/17/08 with diagnoses of Alzheimer's Dementia with Psychosis, Neuropathic Leg Pain, and Glaucoma. A review of the Resident's Minimum Data Set (MDS) dated 02/21/12 revealed Resident #1 required extensive assistance of one person for eating and the extensive assistance of two "plus" persons for dressing and personal hygiene. A review of the Mood and Behavior Symptom Assessment dated 01/04/12 revealed the resident had a severely impaired cognitive deficit.</p> <p>2. A review of the medical record for Resident #2 revealed the resident was admitted to the facility on 12/21/09 with diagnoses of End Stage Huntington's Disease, Functional Decline, Malnutrition, and Psychosis. A review of the Resident's MDS dated 02/22/12 revealed Resident #2 required extensive assistance of one person for eating, and extensive assist of two "plus" persons to assist the resident with dressing and personal hygiene. A review of the Cognitive Assessment/Plan of Care dated 02/22/12 revealed the resident had severe cognitive impairment.</p> <p>Due to Resident #1's and Resident #2's impaired mental status, interviews with the residents were not conducted.</p> <p>An interview with CNA #1 conducted on 03/15/12, at 4:45 PM, revealed she suspected CNA #4 had failed to provide care to residents and allowed</p>	F 225	<ul style="list-style-type: none"> Immediate notification of the to the Administrator or Director of Nursing of an allegation of neglect or abuse. <p>Monitoring: The Quality Assurance Committee will review the Plan of Correction to ensure it is being implemented and carried out. Accidents and Incidents as well as Reportables (Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property) will be reviewed to ensure they are being immediately reported and followed up on as required. This QA Committee review will be for three months beginning April 2012 and ending June 2012.</p>	05/01/12	

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F 225	<p>Continued From page 3</p> <p>residents to wear soiled clothing from the breakfast meal to the lunch meal on numerous occasions. CNA #1 reported she had received training by the facility on abuse and neglect and was aware that any witnessed/suspected abuse or neglect was to be immediately reported to the DON or Administrator. However, CNA #1 acknowledged she failed to report her suspicions of neglect to the Administrator or the DON. An interview with CNA #3 on 03/15/12, at 7:05 PM, revealed she suspected CNA #4 had neglected to provide personal care to residents. According to CNA #3, she had received training by the facility that any suspected abuse or neglect was to be immediately reported to the supervisor but failed to report she suspected CNA #4 neglected residents to the Administrator.</p> <p>An interview with CNA #2 on 03/15/12, at 5:20 PM, revealed she suspected CNA #4 had failed to change the residents' clothing when it became soiled on numerous occasions. CNA #2 acknowledged she had received training from the facility related to abuse and neglect. CNA #2 stated although she reported her suspicions to the DOM she should have immediately reported her observation of Resident #1's and Resident #2's soiled clothing and the suspicion that CNA #4 had neglected the residents' care to the Administrator.</p> <p>An interview with the Director of Maintenance (DOM) on 03/15/12, at 5:45 PM, revealed during a "smoke break" on 03/06/12, CNA #2 reported to him she was concerned staff failed to provide care for Resident #1 and Resident #3 because they had worn clothing that had become soiled during breakfast meals to the lunch meal. The</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>DOM stated he had been trained by the facility to report suspected abuse and/or neglect immediately to the nurse and/or Administrator and should have reported CNA # 2's concern that resident care was being neglected. However, the DOM stated he failed to report the CAN's concern to the nurse and/or Administrator and had instructed CNA #2 to leave any food that spilled onto the residents' clothing at the breakfast meal the next day and if he saw the residents sitting in soiled clothing on his daily rounds he would report it at that time.</p> <p>An interview with CNA #8 conducted on 03/15/12, at 3:20 PM, revealed he became aware of concerns that CNA #4 neglected the care of residents from a conversation he overheard between CNAs #1, #2, and #3 during the breakfast meal on 03/07/12. CNA #8 stated he also overheard CNAs #1, #2, and #3 discuss in their conversation that the DOM was aware of their concerns. In addition, CNA #8 stated that on 03/07/12, during the breakfast meal, he witnessed CNA #1 give Resident #1 a cup of chocolate milk even though the resident was unable to hold a cup. According to CNA #8, the chocolate milk spilled onto the resident's clothing and CNA #1 made no attempt to wipe the milk from the resident's clothing. CNA #8 also stated he witnessed CNAs #2 and #3 "pour" cooked oatmeal onto Resident #2's clothing and that CNAs #2 and #3 failed to clean the oatmeal from the resident's clothing. Although CNA #8 acknowledged he had been trained by the facility to report any allegations of abuse and/or neglect immediately to his supervisor, he stated he failed to report his observations and/or the concerns expressed by CNAs #1, #2, and #3. In addition,</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>CNA #8 stated because the DOM was in a supervisory position, he was afraid to report to the Administrator that the DOM was reportedly aware of the CNA's concerns.</p> <p>An interview with the Regional Clinical Consultant conducted on 03/15/12, at 8:05 PM, revealed she performed "one on one" training on abuse and neglect to all staff in July 2011 and at that time staff was reminded to report all suspected and/or witnessed abuse or neglect immediately to their supervisor.</p> <p>A review of the Abuse/Neglect in-services conducted on 07/27/11 confirmed CNAs #1, #2, #3, #4, and #8 had received training on reporting abuse and neglect. A review of documentation in the personnel file for the DOM, dated 04/12/10, revealed he had also received training on reporting abuse and neglect to the Administrator.</p> <p>Interview with the Administrator on 03/15/12, at 9:20 PM, revealed he had not been informed of the staff's concerns that resident care had been neglected. The Administrator stated staff had been trained on abuse/neglect/exploitation and did not know why they had failed to report their concerns.</p>	F 225			