

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

PRINTED: 02/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/05/2015
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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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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)	(X6) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000 2-9-2015

An Abbreviated Survey investigating KY#00022743 was initiated on 02/04/15 and concluded on 02/05/15. The allegation was substantiated with a deficiency cited.

F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The Facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on interviews, record reviews and a review of the facility's policy, it was determined the facility failed to implement their written policy related to abuse for Unsamped Resident A. The facility failed to report to the appropriate state agencies an allegation of verbal abuse.

The findings include:

Review of the facility's policy titled, "Abuse: Response and Reporting", undated revealed it was the policy of the facility to respond and investigate to all alleged incidents of abuse or neglect and report to the appropriate state agencies. Further review of the policy revealed it was the responsibility of the Social Services Director, Director of Nursing or the Administrator to report to the required agencies.

Record review revealed the facility admitted Unsamped Resident A on 12/11/12, with

Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.

F 226 (D) Develop/Implement Abuse/Neglect, Etc Policies

Targeted Residents

Resident A has a BIMMs score of 1. Resident was assessed on 1-20-15 by the Director of Nursing showing no signs of anxiety, or pain and appeared to be unaffected by this incident. All staff was inserviced on facility abuse policy with an emphasis on types of abuse, abuse reporting and verbal abuse. Inservicing was done on 2-6-15 and 2-9-15 by the Staff Development Coordinator.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela J. Jordan</i>	TITLE <i>Administrator</i>	(X6) DATE 3-9-15
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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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(X5) COMPLETION DATE			

F 226 | Continued From page 1

diagnoses which included Dementia, Peripheral Vascular Disease, Hypertension and Hyperlipidemia. A review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/27/14, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) section C zero five hundred (0500) score of one (1) which indicated the resident was severely cognitive impaired.

A review of the facility's investigation report, dated 01/21/15, revealed the Director of Nursing (DON) was made aware of an allegation of abuse on 01/20/15. The allegation of abuse on 01/20/15 revealed that Licensed Practical Nurse (LPN) #2 and Registered Nurse (RN) #1 reported a staff member spoke to Unsampld Resident A in a negative tone. Continued review of the report revealed the DON completed an investigation and unfounded the allegations. Further review revealed the DON failed to report the allegation to the appropriate state agencies.

An interview on 02/05/15 at 6:10 PM, with the Social Service Director revealed she was notified of the abuse allegation; however, the DON completed the investigation.

An interview on 02/05/15 at 5:25 PM, with the DON, revealed she completed her investigation of the alleged abuse and unfounded the allegation. Continued interview revealed she did not follow the facility's written policy for reporting. She stated, she should have reported the alleged verbal abuse to the state agency.

An interview on 02/05/15 at 5:45 PM, with the Administrator revealed her expectation was that the facility's policy should be followed as written.

F 226:

Identification of the Other Residents
On 1/20/15, Residents that reside on the 200 hall where the nursing assistant was assigned were interviewed by the Director of Nursing utilizing the facility's "Review Questions to Solicit Resident Concerns". No concerns were identified during this review. The residents that were non-interviewable were physically assessed by the Director of Nursing on 1/20/15, with no signs of anxiety or pain.

Systemic Changes
All facility staff was in-serviced on 2/6/2015 and 2/9/2015 on the facility Verbal Abuse and reporting abuse Policies and Procedures. The inservice was conducted by the Staff Development Coordinator. Each employee signed an acknowledgement of understanding. This inservice included educating Facility Administrative staff, as well.

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F 226 Continued From page 2
She further revealed, all allegations of abuse should be reported to the state agencies.

F 226
Monitoring
Post-testing of all employees will be completed monthly by the staff development coordinator. Facility tool, "Review Questions to Solicit Resident Concerns" will be completed for all residents monthly for three months by Social Services Director and Activities Director. All results of the post testing and facility tool results will be referred to the Quality Assurance (QA) committee for recommendations and follow-up. All investigations will be reviewed by Social Services, Director of Nursing and Administrator and Director of Operations consultant to ensure that each is reported timely and appropriately. Each reported investigation will be presented to the Monthly QA meeting and discussed with the medical director for appropriate reporting.

Correction Date
02/25/2015