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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES
FORM APPROVED
OMB NO. 0938-0391

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

PRINTED: 02/16/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/02/2011 |
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| NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41096 |
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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 | | |
| F 225 SS=D | <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 / N 110</p> <p>Resident #1 was affected by the deficient practice and had physician orders obtained in addressing the fracture. Bed rest was initiated for the prescribed amount of time, warm compresses applied, and a portable hip x-ray was ordered on 9/18/10. The facility changed the lift from a standing to a non-weight bearing lift on 9/18/10. A CT scan was ordered and completed on 9/21/10. Resident #2 did not require any medical treatment for the identified bruise area and a head to toe skin assessment was completed on 2/2/11.</p> <p>The facility completed a head to toe skin assessment on all residents, which was completed by 2/9/11. All identified areas were documented and addressed per facility policy.</p> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| <i>X Stacie D. Donald</i> | <i>Administrator</i> | <i>2/24/11</i> |

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 and record review, it was determined the facility failed to ensure that all alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown origin, were reported immediately to the administrator of the facility and to other officials in accordance with the law. The facility failed to ensure evidence was available to show these violations were thoroughly investigated for two (2) of three (3) sampled residents (Residents #1 and #2). Residents #1 and #2 had sustained injuries of unknown origin and the facility failed to investigate those injuries in a timely manner.</p> <p>The findings include:</p> <p>Review of the facility's policy on Abuse, dated 03/06/00, revealed all injuries of unknown origin were to be promptly and thoroughly investigated and documented by facility management and the Administrator and the Director of Nursing Services must be notified immediately. The investigator would review the medical record, interview persons reporting and/or witnessing the incident, interview the resident if appropriate, interview staff, interview other residents and review all events leading up to the incident. The results of the investigation will be recorded on the "Resident Abuse Investigation Report". Should</p> | F 225 | <p>The systemic change that was made within the facility was to implement a video guided head to toe assessment tool and to evaluate all licensed nurses skills on this assessment by 2/25/11 and during orientation of new hires. In addition to the Incident Log Summary, the charge nurse to further investigate the root cause will complete an investigation of Injuries of an Unknown Source form. An in-service was conducted for all nurses by 2/25/11 on abuse/neglect identification as well as procedures to address injuries of unknown origin. An in-service for all nurse aides was completed by 2/25/11 to educate them on the Resident Summary Form to develop a more effective form of communication to address any new areas of concern regarding residents.</p> | |
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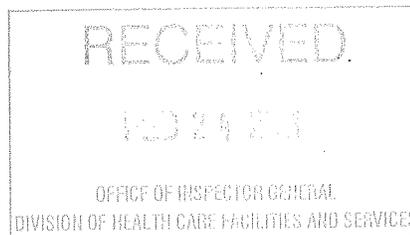
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| F 225 | <p>Continued From page 2</p> <p>the investigation reveal that abuse occurred the administrator will report such findings to the State licensing agency and Adult Protective Services immediately?</p> <p>Continued review of the Abuse policy revealed that mistreatment, abuse, neglect, or any other criminal offense shall be reported immediately. Neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>1. Review of the facility's investigation of Resident #1's bruising of unknown origin revealed the investigation was not initiated until 09/18/10, four (4) days after the first report that the resident had a bruise on the left leg and was not completed until 09/29/10. A written statement from the Quality Assurance Nurse dated 09/27/10 revealed staff members did fail to report and document their findings timely. A written statement from the Administrator dated 09/23/10 revealed abuse was not substantiated.</p> <p>Review of the clinical record for Resident #1 revealed the resident had a significant change Minimum Data Set (MDS) assessment completed on 10/10/10 which revealed the resident had a severe cognitive deficit and was not able to make daily care decisions. The resident required total assistance from staff for all care needs and was unable to communicate their needs. A standing mechanical lift was utilized to move the resident from bed to chair.</p> <p>Further record review revealed that on 09/18/10, reports of bruising and swelling were documented in the nursing notes and the physician was notified. An x-ray was obtained on 09/18/10 and</p> | F 225 | <p>The QA nurse/designee will monitor facility compliance by observing 10 random weekly head to toe skin assessments for the first month and biweekly for six months. The QA nurse/designee will also monitor the Resident Summary Form to ensure that the nurse, per facility policy, addressed concerns identified by the nursing assistants. The form of communication will be audited weekly for one month and biweekly for six months.</p> <p>The findings will be reported to the QA committee on a monthly basis.</p> <p style="text-align: right;">Completion date: 2/25/11</p> | |
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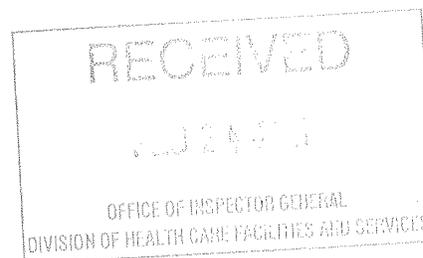
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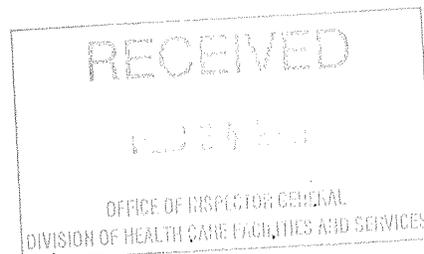
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| F 225 | <p>Continued From page 3</p> <p>an ill defined oblique minimally displaced fracture of the left leg was discovered. A CAT scan was completed on 09/21/10 and revealed an acute spiral fracture of the lower left femur was present. The resident had a diagnosis of Osteopenia.</p> <p>Interview with Certified Nurse Aides (CNA) #1 and #2 on 02/02/10 at 1:15pm revealed they were working with Resident #1 on 09/14/10 when they noticed a large bruise on the resident's left thigh and knee area. They stated they told Licensed Practical Nurse (LPN) #3 about the bruise. They stated the nurse told them she would get it taken care of. They revealed the next night, 09/15/10, they brought the bruise to the attention of LPN #1 and she told them she would get it taken care of. They indicated the nurses told them the bruise had been taken care of. They revealed they were trained on abuse and reporting immediately by the facility when hired and yearly. On 09/16/10, both CNAs revealed they again reported the bruised area to LPN #1 and were reassured everyone knew about the bruise and that it had been reported.</p> <p>Interview with CNA #3 on 02/02/10 at 3:15pm revealed she remembered seeing a bruise on Resident #1's left leg on 09/15/10 while providing care with CNA #4's assistance. She stated they told LPN #4 and were referred to the nurse on the hall where the resident resided. She revealed they did tell the nurse; however, she was not able to remember the name of the nurse. She stated she reported the bruise. She revealed she was trained on abuse and reporting immediately by the facility.</p> <p>Interview with LPN #1 on 02/01/11 at 4:20pm revealed she remembered doing a skin</p> | F 225 | | |
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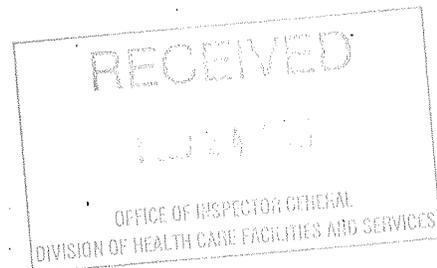
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| F 225 | Continued From page 4 assessment on Resident #1 and finding no bruising. She stated she did see a very light green area around the groin. She denied having been given any information regarding bruising by any CNA. She stated she had been trained on abuse when hired and since the incident with Resident #1. She stated she could not remember if she charted or filled out an incident report. She revealed she did not check the clinical record to see if the bruise had been reported. Interview with LPN #2 on 02/04/10 at 7:30pm revealed she was told by the CNAs that Resident #1 had bruising on the leg around 09/15/10. She stated the bruise looked old and she did not document the bruise. She revealed she could not remember if she reviewed the clinical record to determine if the bruise had been reported. She stated an incident report should have been initiated and the nurse manager informed of the bruise. She stated she had received training on abuse and documentation. Interview with the Registered Nurse (RN) on 02/02/11 at 3:10pm revealed several CNAs came to her on 09/18/10 concerned regarding Resident #1's leg. She stated she assessed the resident and found swelling and bruising and she knew something was wrong. She indicated the CNAs had reported the resident's condition to several nurses and they were not satisfied with the responses they had received. She stated she notified the physician and the responsible party and an x-ray revealed a fracture. Interview with the Assistant Director of Nursing (ADON) on 02/02/11 at 10:50am revealed bruising of unknown origin should have been reported to managers immediately. She stated | F 225 | | |



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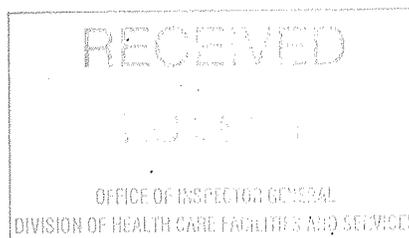
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| F 225 | <p>Continued From page 5</p> <p>not reporting could be neglect and harm could have occurred.</p> <p>2. Review of the clinical record for Resident #2 revealed the facility completed a quarterly MDS assessment on 01/09/11 which revealed the resident could not make decisions regarding care and had short and long term memory deficits. The resident was ambulatory, wandered about the facility at will, and could be combative with care.</p> <p>Record review revealed on 11/05/10 the resident was slapped by another resident. The facility could not provide any evidence the nurse reported the incident, documented on an incident report, or that an investigation was initiated to determine what happened.</p> <p>Further review revealed on 12/25/10 Resident #2 was found with the right hand and wrist a purple color. The facility could not provide any evidence that a nurse reported the incident, completed an incident report or that an investigation was initiated to determine how the injury occurred.</p> <p>Interview with the ADON on 02/02/11 at 5:30pm revealed she was not aware of the injuries to Resident #2 and had no documentation regarding either of the incidents.</p> <p>Interview with the Unit Manager on 02/02/11 at 1:20pm revealed incident reports are completed by the nurse finding an injury as soon as possible and reported to managers. She stated the nurse should try to identify how the injury occurred.</p> <p>Interview with the Quality Assurance Nurse on 02/02/11 at 12:50pm revealed she reviewed the</p> | F 225 | | |



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| F 225 | Continued From page 6 abuse investigation on Resident #1 on 09/27/10 and found no abuse; however, she did not consider neglect. She stated she was not aware of nurses failing to report bruising until the incident with Resident #1. She stated the nurses were provided training on abuse and documentation; however, the nurses were not being supervised to ensure compliance with reporting bruising. | -F 225 | | |
| F 226 SS=D | 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 interview and record review, it was determined the facility failed to implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents for two (2) of three (3) sampled residents (Residents #1 and #2). Residents #1 and #2 had sustained injuries of unknown origin and the facility failed to follow their written policy to report immediately and investigate those injuries promptly. The findings include: Review of the facility's written policy on Abuse, dated 03/06/00, revealed all injuries of unknown origin were to be promptly and thoroughly investigated and documented by facility management and the Administrator and the Director of Nursing Services must be notified immediately. The investigator would review the | F 226 | F 226 / N 105 Resident #1 was affected by the deficient practice and had physician orders obtained in addressing the fracture. Bed rest was initiated for the prescribed amount of time, warm compresses applied, and a portable hip x-ray was ordered on 9/18/10. The facility changed the lift from a standing to a non-weight bearing lift on 9/18/10. A CT scan was ordered and completed on 9/21/10. Resident #2 did not require any medical treatment for the identified bruise area and a head to toe skin assessment was completed on 2/2/11. The facility completed a head to toe skin assessment on all residents, which was completed by 2/9/11. All identified areas were documented and addressed per facility policy. | |



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F 226

Continued From page 7

medical record, interview persons reporting and/or witnessing the incident, interview the resident if appropriate, interview staff, interview other residents and review all events leading up to the incident. The results of the investigation will be recorded on the "Resident Abuse Investigation Report". Should the investigation reveal that abuse occurred the administrator will report such findings to the State licensing agency and Adult Protective Services immediately? Mistreatment, abuse, neglect, or any other criminal offense shall be reported immediately. Neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

1. Review of the facility's investigation of Resident #1's bruising of unknown origin revealed the investigation was not initiated until 09/18/10, four (4) days after the first report that the resident had a bruise on the left leg and was not completed until 09/29/10. A written statement from the Quality Assurance Nurse dated 09/27/10 revealed staff members did fail to follow the policy to report injuries of unknown origin immediately.

Review of the clinical record for Resident #1 revealed the resident had a significant change Minimum Data Set (MDS) assessment completed on 10/10/10 which revealed the resident had a severe cognitive deficit and was not able to make daily care decisions. The resident required total assistance from staff for all care needs and was not able to communicate needs. A standing mechanical lift was utilized to move the resident from bed to chair. On 09/18/10, reports of bruising and swelling were documented in the nursing notes and the physician was notified. An x-ray was obtained on 09/18/10 and an ill defined

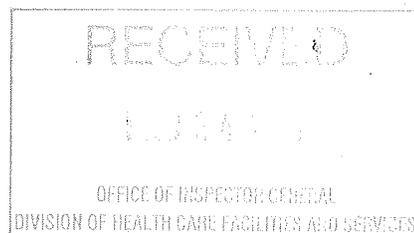
F 226

An in-service was conducted for all nurses by 2/25/11 on abuse/neglect identification as well as procedures to address injuries of unknown origin. The facility updated the resident abuse policies by adding an Injuries of an Unknown Source form, which will be completed by the charge nurse to further investigate the incident. An in-service for all nurse aides was completed by 2/25/11 to educate them on the Resident Summary Form to develop a more effective form of communication to address any new areas of concern regarding residents.

The QA nurse/designee will also monitor the Resident Summary Form to ensure that the nurse per facility policy addressed concerns identified by the nursing assistants. The form of communication will be audited weekly for one month and biweekly for six months.

The findings will be reported to the QA committee monthly.

Completion date: 2/25/11



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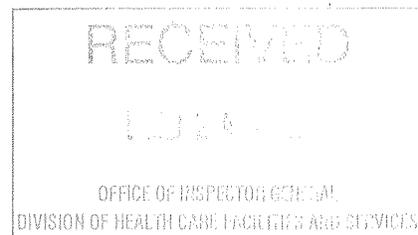
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| F 226 | <p>Continued From page 8</p> <p>oblique minimally displaced fracture of the left leg was discovered. A CAT scan was completed on 09/21/10 and revealed an acute spiral fracture of the lower left femur was present. The resident had a diagnosis of Osteopenia.</p> <p>Interview with Certified Nurse Aides (CNA) #1 and #2 on 02/02/10 at 1:15pm revealed they were working with Resident #1 on 09/14/10 when they noticed a large bruise on the resident's left thigh and knee area. They stated they told Licensed Practical Nurse (LPN) #3 about the bruise. They stated the nurse told them she would get it taken care of. They revealed the next night, 09/15/10, they brought the bruise to the attention of LPN #1 and she told them she would get it taken care of. They indicated the nurses told them the bruise had been reported. They revealed they were trained on abuse and reporting immediately by the facility when hired and yearly. On 09/16/10, both CNAs revealed they again reported the bruised area to LPN #1 and were reassured everyone knew about the bruise and it had been reported.</p> <p>Interview with CNA #3 on 02/02/10 at 3:15pm revealed she remembered seeing a bruise on Resident #1's left leg on 09/15/10 while providing care with CNA #4's assistance. She stated they told LPN #4 and were referred to the nurse on the hall where the resident resided. She revealed they did tell the nurse; however, she was not able to remember the name of the nurse. She stated she did not know if the bruise was reported to management as required. She revealed she was trained on abuse and reporting immediately by the facility.</p> <p>Interview with LPN #1 on 02/01/11 at 4:20pm</p> | F 226 | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

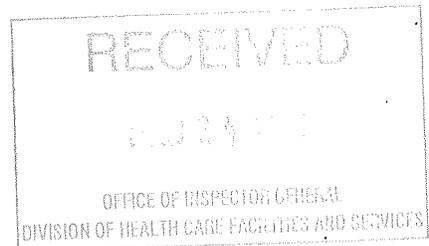
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/02/2011 |
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| NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095 |
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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 226 | <p>Continued From page 9</p> <p>revealed she remembered doing a skin assessment on Resident #1 and finding no bruising. She stated she did see a very light green area around the groin the next day. She stated she had been trained on abuse when hired and since the incident with Resident #1. She revealed she did not report the bruising to management.</p> <p>Interview with LPN #2 on 02/04/10 at 7:30pm revealed she was told by CNAs that Resident #1 had bruising on the leg around 09/15/10. She stated the bruise looked old and she did not document the bruise. She revealed she could not remember if she reviewed the clinical record to determine if the bruise had been reported and she did not report the bruise to management. She stated she had received training on abuse.</p> <p>Interview with the Registered Nurse (RN) on 02/02/11 at 3:10pm revealed several CNAs came to her on 09/18/10 with concerns regarding Resident #1's leg. She stated she assessed the resident and found swelling and bruising and she knew something was wrong. She indicated the CNAs had reported the resident's condition to several nurses and they were not satisfied with the responses they had received. She stated she notified the physician and the responsible party and an x-ray revealed a fracture. She stated she reported to management immediately.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 02/02/11 at 10:50am revealed bruising of unknown origin should have been reported to managers immediately. She stated not reporting could be neglect and harm could have occurred.</p> | F 226 | | |
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| F 226 | <p>Continued From page 10</p> <p>2. Review of the clinical record for Resident #2 revealed the facility completed a quarterly MDS assessment on 01/09/11 which revealed the resident could not make decisions regarding care and had short and long term memory deficits. The resident was ambulatory and wandered about the facility at will. In addition, the resident could be combative with care. On 11/05/10 the resident was slapped by another resident. The facility could not provide any evidence the nurse reported the incident, documented on an incident report or that an investigation was initiated to determine what happened. On 12/25/10 the resident was found with the right hand and wrist a purple color. The facility could not provide any evidence that a nurse reported the incident, completed an incident report or that an investigation was initiated to determine how the injury occurred.</p> <p>Interview with the ADON on 02/02/11 at 5:30pm revealed she was not made aware of the bruise of unknown origin to Resident #2 by the nursing staff.</p> <p>Interview with the Unit Manager on 02/02/11 at 1:20pm revealed bruises of unknown origin were to be reported to managers immediately. She did not know if the bruising to Resident #2 was reported.</p> | F 226 | | | |

