

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

PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391

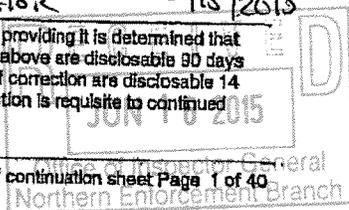
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2015
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NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 590 ROGERSVILLE RD. RADCLIFF, KY 40160
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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 05/20/15 and concluded on 05/26/15 to investigate KY23265 and KY23266. The Division of Health Care substantiated KY23265 with deficiencies cited and KY23266 was unsubstantiated with related deficiencies cited.	F 000	This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because North Hardin Health & Rehabilitation Center Agrees with the citations noted on the page of this Statement of Deficiencies.	
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	F 225	F 225 1. Resident #8 transferred to another facility, at her request, on January 6, 2015. Un-sampled resident "L" was interviewed concerning her allegation and stated the event had not occurred and the Certified Nurse's Assistant had not actually made the statement. Un-sampled resident "L" had no complaints about staff mistreating her and she felt safe at the facility. 2. Social Services staff will conduct interviews with interview-able residents to determine if any residents have concerns about safety or staff treatment. These interviews will be completed by 06/26/2015	Completion by: 06/27/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christopher Thorne TITLE: ASSISTANT ADMINISTRATOR (X6) DATE: 6/15/2015

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.

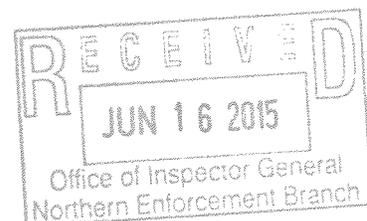


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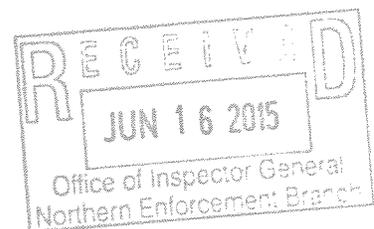
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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the 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, review of the facility's abuse policy, and grievance forms, it was determined the facility failed to have an effective system in place to protect residents from potential abuse after allegations of abuse were reported to staff for one (1) of eight (8) sampled residents (Resident #8) and one (1) of eighteen (18) Unsampled Resident (Unsampled Resident L). The facility failed to investigate or report an abuse allegation by Resident #8 sometime around 11/15/14. In addition, the CMT was allowed to continue to care for residents until 12/28/15. The facility further failed to investigate the abuse allegation by Unsampled Resident L and failed to protect the resident from further abuse.</p> <p>The findings include:</p> <p>Review of the facility's Abuse policy, dated 02/05/03, revealed any incident of abuse or suspected abuse, must be reported immediately to the available charge staff, and then to the Director of Nursing (DON) and Administrator. Any individual suspected of causing abuse was to be removed from direct patient care and reassigned to non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was</p>	F 225	<p>3. Social Services Director will create an investigation Guide for staff use in conducting investigation as well as the process of reporting allegations of abuse. Guides will be kept at both nurses stations and at the receptionist desk. Staff will be in-serviced on the abuse reporting investigation process by the Staff Development Coordinator by 06/26/2015. Social Services Director & Social Services Assistant will receive training on facility abuse policy, reporting guidelines and investigation process by the Administrator and Assistant Administrator by 6/17/2015. Social Services Director will train Department Directors on the Abuse Policy, Reporting, and investigation process by 06/25/2015.</p> <p>4. Social Services Director will attend Resident Council Quarterly for 1 year to ask about abuse and safety. Results of these interviews will be reported to Quality Assurance Committee quarterly for 1 year. Interview-able residents will be interviewed regarding abuse & safety quarterly with their scheduled MDS assessment for 1 year. Results will be reported in Quality Assurance Committee meetings quarterly for 1 year.</p>	Completion by: 06/27/2015



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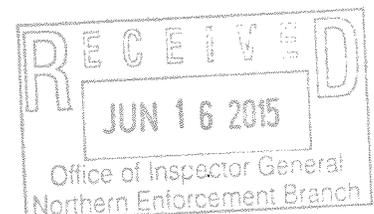
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F 225	Continued From page 2 made by the Administrator of the facility. An incident of suspected abuse per the definitions of this policy, was to be reported to the Department of Community Based Services (DCBS) and the Division of Long Term Care immediately. Events that should be reported and would be investigated included verbal reports/complaints by the resident or family. The Abuse policy stated the following steps would be taken to ensure a complete investigation and reporting of the incident: the Administrator and Supervisory Staff would make all reasonable efforts to address and investigate concerns or grievances presented to them; a statement from the individual reported to have committed the act would be obtained; other staff, residents, and visitors would be interviewed and statements obtained as indicated; the results of the investigation of the reported incident would be documented with the resident's name, the name of the individual reported to be responsible for the incident, specific facts obtained in relation to the incident, type of offense and description of any injury if present; and, other information should be included that assisted in forming the necessary conclusion and supports the presence or absence of an act of abuse. Copies of all statements obtained during the course of the investigation would be attached to the report. All relevant interviews would be conducted to obtain necessary information as quickly as possible following the report of an incident. A copy of the final report would be submitted to DCBS and the Division of Long Term Care within five (5) working days. Interview with the Administrator, 05/21/15 at 10:07 AM, revealed he would be informed of any allegations of abuse, but the Director of Nursing (DON) or Social Workers conducted the	F 225		



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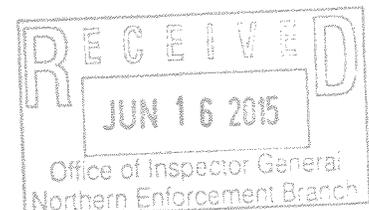
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F 225	<p>Continued From page 3</p> <p>investigation. They would inform him of the findings. He was kept abreast of the abuse investigation, suspension and termination of staff, and reporting requirements.</p> <p>Interview with Social Service Worker (SSW) #1 and #2, on 05/21/15 at 10:13 AM, revealed they conducted most of the abuse investigations once an allegation was received. They stated the DON would conduct the abuse investigation if it involved nursing staff. Once an abuse allegation was received, a Grievance form was filled out with interviews from residents, family, and staff. They stated if the allegation was against a staff member, they were suspended immediately until completion of the abuse investigation. They also reported the abuse allegation to the state agencies. The Administrator was notified immediately, they did the leg work and reported back to him. SSW #1 stated she had not received any abuse allegations recently, but had placed concerns on the Grievance forms.</p> <p>Review of a Grievance form, completed on 11/19/14 by the DON, revealed a discourteous exchange took place between a CMT and Resident #8. The action taken was for the employee to be suspended for three (3) days. No information of what the discourteous exchange was or follow-up was documented on the form. In addition, there was no documented evidence the family, Director of Social Services, or the Administrator was notified.</p> <p>The form had a statement letter attached from the Activity Assistant (who no longer works at the facility). Review of the statement letter, not dated, revealed Resident #8 reported some situations (no explanation) had occurred that made the</p>	F 225			



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F 225	<p>Continued From page 4</p> <p>resident uncomfortable and breached his/her rights and privacy. Resident #8 reported CMT #1 degraded the resident on several occasions and the CMT told the resident she did not have time for this today, and to go away, she would get the resident later. The letter stated the resident feared the nights the CMT worked and was afraid if he/she defended themselves, the CMT would retaliate or cause them harm. According to the letter, the resident had reported these concerns to nurses (no names given) last week.</p> <p>In addition to the Grievance form and the statement letter; six (6) residents were interviewed on 11/18/14 by the East Wing Unit Manager. The interview sheet stated, upon receiving a complaint from a resident's family member in regards to CMT #1, interviews were held with other alert and oriented residents under her care on a regular bases. Relevant findings from the interviews are listed below:</p> <p>1. Room 4 E-2 (Resident #8) stated she was always two hours late with the resident's pain pill. She told the resident that they were talking on the phone too much and she didn't have time to keep plugging up the phone charger. This had gone on for long time, but the resident was too scared to say anything.</p> <p>2. Room 5 E-1 stated she came in and turned the call light off without fixing what was wrong or would tell the resident she would go get the aide and not get them. The resident asked her to turn the fan down a little because he/she was cold. She just turned it away from the resident and then told him/her they needed to say please next time. The resident was afraid to say anything because she could do harm. The resident just dreaded</p>	F 225			

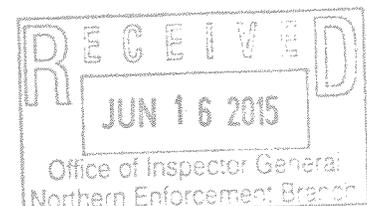


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F 225	<p>Continued From page 5 when she was there.</p> <p>3. Room 7 E-2 stated they get their medication whenever she felt like it. She had a smart mouth, but the resident could ignore it.</p> <p>4. Room 9 E stated they just did not feel safe with her down here. The resident did not feel she could help them if they needed it.</p> <p>5. Room 12 E had no concerns.</p> <p>6. Room 12 E had no concerns</p> <p>Interview with the DON, on 05/21/15 at 11:05 AM, revealed she had interviewed CMT #1 regarding Resident #8's concerns, but did not document anything. She said the CMT refused to provide a written statement. She stated she had suspended the CMT because she was rude to the residents. She had not considered the Grievance report to be an allegation of abuse. She stated she didn't see it as verbal abuse, just rude. She stated the CMT position was eliminated in December 2015 and the CMT was laid off and had not worked at the Nursing Facility since then. She stated she had not followed up on the residents' interviews that revealed they were afraid of the CMT. She said she had spoken with a few residents and they were satisfied with the facility's actions so she did not pursue the matter any further. She stated since the residents did not say the word verbal or physical abuse, she did not consider them to be a reportable allegation of abuse. However, she had no documentation of interviews with any residents or staff. She had not conducted an investigation of the allegations received from Resident #8 or the other residents and had not investigated why the residents were afraid of CMT #1. She stated the only documentation regarding Resident #8's allegation was on the Grievance form. She did not know</p>	F 225		

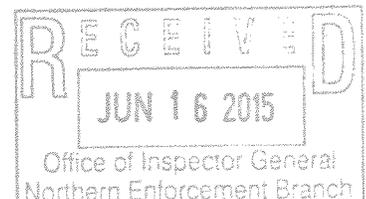


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F 225	<p>Continued From page 6</p> <p>when the statement letter was written and could not find any documentation of the incident in the medical record. She stated she had informed the Administrator verbally, but not in writing. She revealed she had not completed a report because she had not considered it an allegation of abuse. She stated it was at her discretion if she would discipline staff or not.</p> <p>Request for the suspension notice for CMT #1 revealed the DON did not give an official suspension only wrote it on the staffing sheet. Review of the staffing sheet for November 15, 16, and 17, 2014 revealed someone had crossed through the CMT #1's name and wrote three (3) day suspension beside her name. However, review of the CMT's timesheet for November 15, 16, and 17, 2014 revealed the CMT had worked on those days. Review of the CMT's personnel record revealed no suspension notice. The CMT's last working day was December 28, 2014.</p> <p>A telephone interview with CMT #1, on 05/26/15 at 2:45 PM, revealed she did not know anything about residents complaining about her. She stated she received no written discipline notice or suspension from the DON. She stated she did not recall anything about the incident and refused to answer any questions. She confirmed she had not worked at the facility since December 2014.</p> <p>Interview with the Administrator, with the Administrator in training present, on 05/21/15 at 5:07 PM, revealed the DON and SSW do the abuse investigations and report the findings to him and he decides if there is something to talk about. He said he had not received any abuse allegations reports. He revealed the only training the SSW and DON received on how to conduct</p>	F 225		

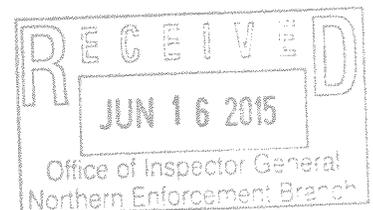


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F 225	<p>Continued From page 7</p> <p>abuse allegations was training on the facility's abuse policy. He stated they should understand what abuse allegations are. He stated he usually reviewed all abuse investigations, but had not received anything regarding this incident. He stated he recalled talking with the Unit Manager (who was no longer working at the facility) about the residents interviewed, but he was told the residents considered the CMT as rude. The Administrator searched for additional documented evidence an investigation was conducted of the incident and found none. He stated he had not seen the documented interviews where the residents stated they were afraid of the CMT and it bothered him that the residents were afraid. He reviewed the written statement and the residents' interviews and stated the way it was written, he would have considered it to be an allegation of abuse that needed to be investigated. He said he told the Unit Manager to suspend the CMT and investigate. However, he did not follow up to ensure that was done. He stated it was his responsibility and he did not ensure the abuse allegation was investigated or reported.</p> <p>Resident #8 no longer lives at the facility. Only two (2) of the original six (6) residents that were interviewed on 11/18/14 were still at the facility. Interview with Unsampled Residents G, on 05/26/15 at 9:15 AM and Unsampled Resident H, on 05/26/15 at 9:19 AM, revealed they had no problems with the staff now and denied any abuse toward them.</p> <p>Interviews with other residents during the course of the survey revealed no abuse was alleged.</p> <p>Review of Resident #8's closed record revealed</p>	F 225		

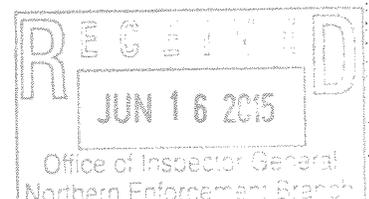


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F 225	<p>Continued From page 8</p> <p>the facility discharged the resident to another nursing facility on 01/16/15. Review of the discharge summary revealed the resident was pleasant, alert and oriented. Review of the last quarterly assessment completed on 01/12/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) with a score of a thirteen (13) out of possible fifteen (15) which meant the resident was interviewable. The facility assessed the resident to have no behaviors, but needed extensive assist of two-persons for transfers and toileting and one-person for transfers and ambulation.</p> <p>2. Review of Unsampled Resident L clinical record revealed the facility assessed the resident with a BIMS score of a fourteen (14) out of a possible fifteen (15) which meant the resident was interviewable.</p> <p>Interview with Resident L, on 05/26/15 at 9:00 AM, revealed about a month ago Certified Nursing Assistant (CNA) #13 verbally mistreated the resident and called him/her a liar. The resident stated the CNA came into work, but told the resident she did not want to be there. The resident stated the CNA was upset about something and had a mean attitude. The resident felt like the CNA took it out on him/her by pushing the resident to do things for themselves instead of assisting the resident. The resident went up to the nurses desk to complained about the CNA. The CNA came up to the nurses station and called the resident a liar in front of other staff. The resident could not recall the names of the staff who were at the nurses station. The resident said it was not right for the CNA to say that to him/her, especially in front of other people. The resident</p>	F 225		

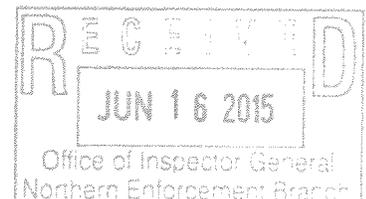


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F 225	<p>Continued From page 9</p> <p>stated it was sort of verbal abuse. The resident stated no other staff person followed up or asked the resident what happened after the incident. The resident stated the CNA did not assist him/her any longer and the only time the CNA came into the room was to take the roommate to the shower.</p> <p>CNA #13 was not available for interview as she no longer worked at the facility.</p> <p>Interview with the West Wing Unit Manager, on 05/26/15 at 10:45 AM, revealed she was not aware of anyone calling Unsamped Resident L a liar and unaware of any reports of verbal abuse.</p> <p>Interview with the DON, on 05/21/15 at 4:45 PM, revealed verbal abuse was talking to the resident in a degrading, demeaning manner. The normal procedure for investigating suspected abuse was to remove the person from the area and send them home pending further investigation. She would ask other residents if there was a problem. If another resident said they were afraid of the staff member she would try to find out what they were scared of and offer reassurance. She would interview other staff colleagues. She would then follow through with appropriate interventions. Those interventions may include re-education of the staff, suspensions, and sometimes it could be the perception of the resident. The DON stated after the information was gathered it was to be discussed with the Administrator and a determination of whether to report it to the state would be made. The DON stated they had twenty-four hours to report it to the Office of the Inspector General (OIG). The DON stated she had been the DON for a year and had not reported any abuse allegations to the OIG.</p>	F 225		

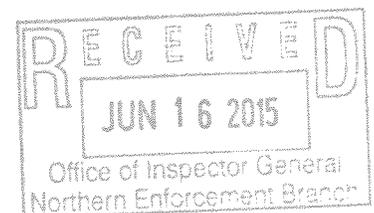


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2015
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	

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F 225	Continued From page 10 Interview with Social Workers #1 and #2, on 05/26/15 at 10:00 AM, revealed they were not aware of any investigation concerning Unsampled Resident L being called a liar. Social Worker #1 stated verbal abuse was a type of abuse and should be investigated. The social worker further stated once the resident was safe the DON should be notified and the DON would determine if that staff member should be suspended. The social worker further stated an investigation should include interviews from other residents, staff, and any witnesses to the suspected abuse. If the CNA continued to work around the resident she would interview the resident and see if there was a reason why that CNA was having contact with the resident. She further stated if there was no reason she would talk to the Administrator, DON and the Assistant Director of Nursing (ADON) to find out why that CNA had been working with the resident. If during the course of the investigation another resident stated they had been afraid of the staff member it should be investigated further and documented in writing as to why they had been afraid. The Social Worker stated they had a form they used to document the actions taken and what they had done.	F 225	F 226 1. Resident #8 transferred to another facility, at her request, on January 6, 2015. Un-sampled resident "L" was interviewed concerning her allegation and stated the event had not occurred and the Certified Nurse's Assistant had not actually made the statement. Un-sampled resident "L" had no complaints about staff mistreating her and she felt safe at the facility. 2. Social Services staff will conduct interviews with interview-able residents to determine if any residents have concerns about safety or staff treatment. These interviews will be completed by 06/26/2015 3. Social Services Director will create an investigation Guide for staff use in conducting investigation as well as the process of reporting allegations of abuse. Guides will be kept at both nurses stations and at the receptionist desk. Staff will be in-serviced on the abuse reporting investigation process by the Staff Development Coordinator by 06/26/2015. Social Services Director & Social Services Assistant will receive training on facility abuse policy, reporting guidelines and investigation process by the Administrator and Assistant Administrator by	
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.	F 226		Completion by: 06/27/2015

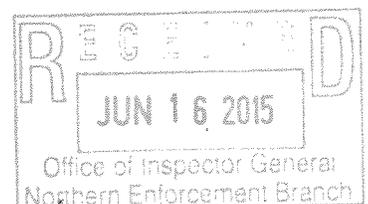


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F 226	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure their Abuse policy was implemented for one (1) of eight (8) sampled residents (Resident #8) and one (1) of eighteen unsampled residents (Unsampled Resident L). The facility failed to investigate and report an abuse allegation by Resident #8 according to their abuse policy. In addition, the facility failed to protect the residents from further abuse when they allowed CMT #1 to continue to care for residents. The facility failed to investigate the abuse allegation by Unsampled Resident L that CNA #13 called the resident a liar and failed to protect the residents from further abuse.</p> <p>The findings include:</p> <p>Review of the facility's Abuse policy, dated 02/05/03, revealed any incident of abuse or suspected abuse, must be reported immediately to the available charge staff, and then to the Director of Nursing (DON), and Administrator. Any individual suspected of causing abuse was to be removed from direct patient care and reassigned to non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was made by the Administrator of the facility. An incident of suspected abuse per the definitions of this policy, was to be reported to the Department of Community Based Services (DCBS) and the Division of Long Term Care immediately. Events that should be reported and would be investigated included verbal reports/complaints by the resident or family. The Abuse policy stated the following</p>	F 226	<p>06/17/2015. Social Services Director will train Department Directors on the Abuse Policy, Reporting, and investigation process by 06/25/2015.</p> <p>4. Social Services Director will attend Resident Council Quarterly for 1 year to ask about abuse and safety. Results of these interviews will be reported to Quality Assurance Committee quarterly for 1 year. Interview-able residents will be interviewed regarding abuse & safety quarterly with their scheduled MDS assessment for 1 year. Results will be reported in Quality Assurance Committee meetings quarterly for 1 year.</p>	Completion by: 06/27/2015



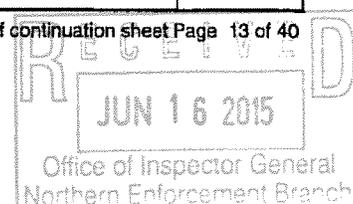
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F 226	<p>Continued From page 12</p> <p>steps would be taken to ensure a complete investigation and reporting of the incident: the Administrator and Supervisory Staff would make all reasonable efforts to address and investigate concerns or grievances presented to them; a statement from the individual reported to have committed the act would be obtained; other staff, residents, and visitors would be interviewed and statements obtained as indicated; the results of the investigation of the reported incident would be documented with the resident's name, the name of the individual reported to be responsible for the incident, specific facts obtained in relation to the incident, type of offense and description of any injury if present, and other information should be included that assisted in forming the necessary conclusion and supports the presence or absence of an act of abuse. Copies of all statements obtained during the course of the investigation would be attached to the report. All relevant interviews would be conducted to obtain necessary information as quickly as possible following the report of an incident. A copy of the final report would be submitted to DCBS and Division of Long Term Care within five (5) working days.</p> <p>Interview with Social Service Worker (SSW) #1 and #2, on 05/21/15 at 10:13 AM, revealed they conducted most abuse investigations once an allegation was received. They stated the DON would conduct the abuse investigation if it involved nursing staff. Once an abuse allegation was received, a Grievance form was filled out with interviews from residents, family, and staff. They stated if the allegation was against a staff member, they were suspended immediately until completion of the abuse investigation. They also reported the abuse allegation to the state</p>	F 226		



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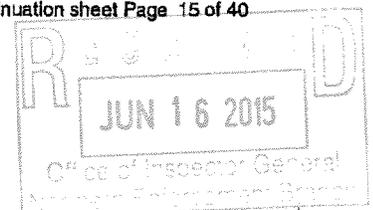
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F 226	<p>Continued From page 13</p> <p>agencies. The Administrator was notified immediately. SSW #1 stated she had not received any abuse allegations recently, but had placed concerns on the Grievance forms.</p> <p>Review of a Grievance form, completed on 11/19/14 by the DON, revealed a discourteous exchange by a CMT toward Resident #8 had taken place. No information of what the discourteous exchange was or follow-up was documented on the form. In addition, a statement letter from the Activity Assistant (who no longer works at the facility) was attached. Review of the statement letter, not dated, revealed Resident #8 reported some situations (no explanation) had occurred that made the resident uncomfortable that breached his/her rights and privacy. Resident #8 reported CMT #1 degraded the resident on several occasions and the CMT told the resident she did not have time for this today, and go away, she would get the resident later. The letter stated the resident feared the nights the CMT worked and was afraid if he/she defended themselves, the CMT would retaliate or cause harm to the resident. According to the letter, the resident had reported these concerns to nurses (no names given) last week.</p> <p>In addition to the Grievance form and the statement letter, six (6) residents were interviewed on 11/18/14 by the East Wing Unit Manager. The interviews were with residents the facility had assessed to be alert and oriented. These residents had been under CMT #1's care on a regular bases. Relevant findings from the interviews revealed two (2) out the six (6) residents voiced they were afraid of CMT #1. Refer to F225.</p>	F 226		

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F 226	<p>Continued From page 14</p> <p>Interview with the Director of Nursing, on 05/21/15 at 11:05 AM, revealed she had interviewed CMT #1 regarding Resident #8's concerns, but did not document anything. She said the CMT refused to provide a written statement. She had not considered the Grievance report to be an allegation of verbal abuse. She stated the CMT was just rude. Therefore, she had not conducted an investigation or reported the abuse allegation according to the facility's abuse policy. She stated she had suspended the CMT for the days of November 15, 16, 17, 2015 because she was rude to the resident, but not abusive. However, the DON could not provide written documentation of the CMT's suspension and review of the CMT's timesheet revealed she had worked those days. Continued review of the CMT's timesheet revealed she had worked with residents on the following days: November 25, 26, 28, and 29th. The CMT worked and cared for residents on December 2, 4, 5, 8, 9, 10, 13, 14, 15, 17, 19, 25, 26, 27, and 28 th. She stated it was at her discretion if she would discipline staff or not.</p> <p>Continued interview with the DON revealed she had not investigated further when the other residents' interviewed indicated they were afraid of CMT #1. She stated she had knowledge of the statement letter, but did not know when it had been written and could not find any documentation of the incident in the medical record. She stated she had informed the Administrator of the incident verbally, but had not provided a written report.</p> <p>Interview with the Administrator, on 05/21/15 at 5:07 PM, revealed the DON and SSW do the abuse investigations and report the findings to</p>	F 226		

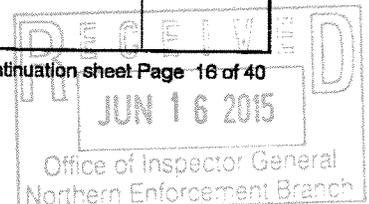


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F 226	<p>Continued From page 15</p> <p>him and he decides if there is something to talk about. He said he had not received any abuse allegations reports. He stated the only training the SSW and DON received on how to conduct abuse allegations was training on the facility's abuse policy. He stated they should understand what abuse allegations are. He stated he usually reviewed all abuse investigations, but had not received anything regarding the incident with Resident #8. He was unaware of the other residents interviews, he had been told the CMT was rude. He reviewed the written statement and the residents' interviews and stated the way it was written, he would have considered it to be an allegation of abuse that needed investigated. He stated it was his responsibility and he did not ensure the abuse allegations were investigated or reported according to the abuse policy. In addition, he thought the CMT had been suspended and was unaware the CMT continued to work and care for residents after the allegation was received.</p> <p>2. Review of Unsampled Resident L's clinical record revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident with a score of fourteen (14) which meant the resident was interviewable.</p> <p>Interview with Unsampled Resident L, on 05/26/15 at 9:00 AM, revealed about a month ago Certified Nursing Assistant (CNA) #13 verbally mistreated him/her and called the resident a liar. The resident stated the CNA came into work, but told the resident she did not want to be there. The resident stated the CNA was upset about something and had a mean attitude. The resident stated the CNA took it out on him/her by saying</p>	F 226		



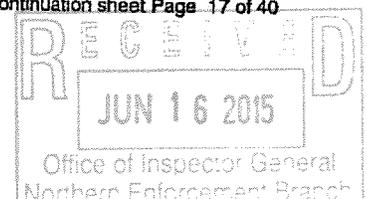
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F 226	<p>Continued From page 16</p> <p>things like, you do this and you do that, instead of assisting the resident. The resident went up to the nurses' station to complain about the CNA's attitude. The CNA came up to the nurses' station and called the resident a liar in front of several staff who were at the nurses' station at that time. The resident did not recall the names of the staff at the nurses' station. The resident was upset and stated it was not right for the CNA to call him/her a liar in front of other people. The resident revealed it was sort of verbal abuse. The resident revealed no other staff person followed up with her on what had occurred. CNA #13 could no longer assist the resident, but she come into the resident's room caring for his/her roommate.</p> <p>Interview with the DON, on 05/21/15 at 4:45 PM, revealed abuse was talking to the resident in a degrading demeaning manner. The normal procedure for investigating suspected abuse was to remove the person from the area and send them home pending further investigation. She would ask other residents if there was a problem. If another resident said they had been afraid of the staff member she would try to find out what they had been scared of and offer reassurance. She would interview other staff colleagues. She would then follow through with appropriate interventions. Those interventions may include re-education of the staff, suspensions, and sometimes it was only a matter of perception by the resident. The DON stated after the information was gathered it was to be discussed with the Administrator and a determination of whether to report it to the state would be made. The DON stated they had twenty-four hours to report it to the Office of the Inspector General (OIG).</p>	F 226		

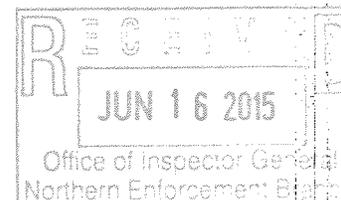


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F 226	Continued From page 17 Interview with the West Wing Unit Manager, on 05/26/15 at 10:45 AM, revealed she was not aware of anyone calling Unsampld Resident L a liar. Interview with Social Worker #1 and #2, on 5/26/15 at 10:00 AM, revealed they had not had any reports about the incident. Social Worker #1 stated verbal abuse was a type of abuse and should have been investigated. The social worker further stated once the resident was safe the Director of Nursing (DON) should be notified and the DON would determine if that staff member should be suspended. The social worker further stated an abuse investigation consisted of interviewing other residents, staff, and any witnesses to the abuse. If the CNA continued to work around the resident she would interview the resident and see if there was a reason why that CNA was having contact with the resident. She further stated if there was no reason for the contact she would talk to the Administrator, DON and the Assistant Director of Nursing (ADON) to find out why that CNA was working with the resident. If during the course of the investigation another resident stated they were afraid of the staff member it should be investigated further and documented in writing of why they were afraid. The Social Worker stated they had a form they used to document the actions taken and what they had done. However, there was no documentation regarding the incident between Unsampld Resident L and CNA #13.	F 226		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246	F 246 1. Residents identified were observed to ensure call lights were within reach of residents per resident care plan.	Completion by: 06/27/2015

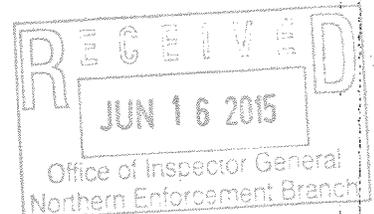


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F 246	<p>Continued From page 18</p> <p>services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have call lights accessible for all residents. Observations on 05/20/15, 05/21/15 and 05/26/15 revealed call lights were not accessible for one (1) of eight (8) sampled residents (Resident #4) and six (6) of eighteen (18) unsampled residents (Unsampled Residents H, I, J, K, N, and O).</p> <p>The findings include:</p> <p>Review of a fax cover sheet, dated 05/29/15, revealed the Assistant Director of Nursing (ADON) documented she could not find a facility policy for call lights.</p> <p>1. Observations on the initial tour, on 05/20/15 at 2:30 PM, revealed Unsampled Resident I was lying in bed, resting with eyes closed. The call light was wrapped around the quarter side rail multiple times and not within the reach of the resident.</p> <p>2. Observation of Unsampled Resident N, on 05/20/15 at 2:35 PM, revealed the call light was attached to the code alarm on the wall and not within the reach of the resident who was in the</p>	F 246	<p>2. Walking rounds were completed 06/02/2015 to ensure call lights were properly placed and in reach of residents. Certified Nurses Assistant's assignment sheets were reviewed to ensure accuracy of resident information.</p> <p>3. Certified Nurse's Assistant's assignment sheets were reviewed to ensure resident information and instructions were accurate and complete. Nursing staff was in-serviced on proper placement of call lights on 06/03/2015. Assistant Director of Nursing will complete call light placement audit daily (Monday through Friday) for 2 weeks beginning 06/02/2015, weekly for 4 weeks beginning 06/17/2015 and monthly for 3 months beginning 07/17/2015. Results of audits will be reported to Quality Assurance Committee during the October 2015 quarterly meeting.</p> <p>4. Assistant Director of Nursing will complete call light placement audit daily for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Results of audits will be reported to Quality Assurance Committee in October 2015.</p>	Completion by: 06/27/2015

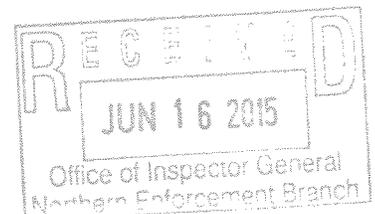


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NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	

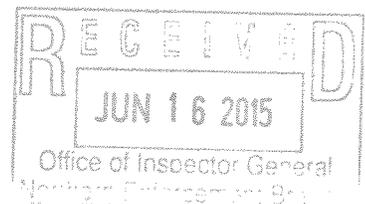
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	<p>Continued From page 19 bed.</p> <p>3. Observation of Resident #4, on 05/20/15 at 2:40 PM, revealed the resident was laying in bed on their back with the call light attached to the code alarm on the wall and not within reach of the resident.</p> <p>Observation of Resident #4, on 05/21/15 at 8:05 AM, revealed the resident was lying in bed on his/her back with the call light attached to the code alarm on the wall. The staff had just exited the room and did not put the call light within reach of the resident.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated 03/25/15 for Resident #4, revealed the facility had conducted a Brief Interview for Mental Status (BIMS) with a score of eight (8) out of possible fifteen (15). Review of the comprehensive care plan, dated 01/30/15, revealed the facility assessed Resident #4 at risk for falls and one of the interventions was to keep frequently used items, especially the call light, within reach of the resident at all times.</p> <p>4. Observation of Unsampled Resident J, on 05/20/15 at 2:50 PM and 3:50 PM, revealed the resident was laying in a low bed on their back. The call light was attached to the code alarm on the wall. When the resident was asked if he/she could reach the call light the resident shook his/her head no.</p> <p>Observation, on 05/21/15 at 1:23 PM, of Unsampled Resident J revealed the resident was laying in bed with the call light out of reach of the resident. The call light was attached to the code</p>	F 246		



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F 246	<p>Continued From page 20 alarm on the wall.</p> <p>Review of Unsampled Resident J's care plan, dated 05/02/12 and revised on March 20015, revealed the resident had a history of falls and one of the interventions was to keep frequently used items, including the call light, within reach of the resident at all times.</p> <p>Interview with CNA #10, on 05/21/15 at 1:30 PM, revealed the call light should be in reach of Resident J. She stated she planned on coming back to the resident's room to place the call light in reach.</p> <p>5. Observation of Unsampled Resident K, on 05/20/15 at 2:55 PM and 3:50 PM, revealed the resident was laying in bed on the left side with his/her eyes closed. The call light was attached to the code alarm on the wall and not within the resident's reach.</p> <p>Observation, on 05/21/15 at 9:25 AM, 11:55 AM, and 1:23 PM, of Unsampled Resident K revealed the resident was laying in the bed and the call light was attached to the code alarm on the wall.</p> <p>Review of Unsampled Resident K's care plan, dated 04/06/15, revealed the resident was at risk for falls and one of the interventions was to keep frequently used items within reach at all times.</p> <p>Interview with CNA #10, on 05/21/15 at 2:50 PM, revealed Unsampled Resident K did not use the call light and she would just listen for him/her to scream. The CNA stated when the resident screamed that meant he/she needed something and she would assist them.</p>	F 246		

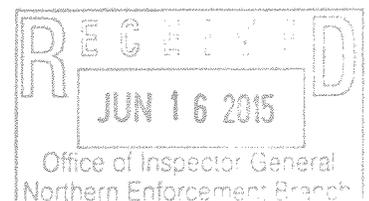


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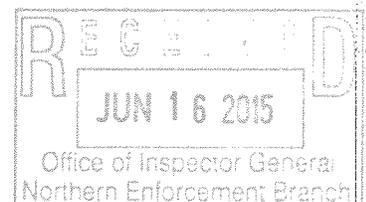
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F 246	<p>Continued From page 21</p> <p>6. Observation of Unsampled Resident O, on 05/20/15 at 3:50 PM, revealed the resident was lying on a low bed with mats on the floor. The call light was attached to the code alarm on the wall and not within reach of the resident.</p> <p>Interview with the West Wing Unit Manager, on 05/21/15 at 3:15 PM, revealed the call light should be within reach of the resident and if it was up on the code alarm on the wall the resident would not be able to reach it. The Unit Manager stated if the resident could not reach the call light it would put them at risk for falling out of bed, trying to reach for it. She stated if the resident was choking, thirsty, or needed something they would not be able to let their needs be known if the call light was out of their reach.</p> <p>7. Observation of Unsampled Resident H, on 05/26/15 at 9:19 AM, revealed the resident sitting up in a recliner that was positioned at least three (3) feet from the bed. The call light cord was wrapped around the side rail out of the resident's reach. Interview during the observation at 9:19 AM, with the resident revealed he/she would transfer self if he/she needed to get into bed or use the call light.</p> <p>Review of the clinical record revealed the resident was recently transferred from the Personal Care Home (PCH) Unit on 05/12/15 related to a decline in Activities of Daily Living (ADL) and falls. The clinical record revealed the resident had numerous falls in the PCH Unit. Review of the admission MDS, dated 05/19/15, revealed the facility assessed the resident to be at high risk for falls related to a history of falling. The resident's</p>	F 246		



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F 246	<p>Continued From page 22</p> <p>BIMS score was a thirteen (13) out of possible fifteen (15) and the facility assessed the resident to require limited assist of one for bed mobility and transfers. The facility identified the resident's balance was not steady when the resident moved from seated to a standing position. Review of the Care Assessment Area (CAA), dated 05/19/15, revealed the resident had a history of falls related to unassisted transfers. The CAA stated the resident fell when attempting to transfer without staff assistance from the chair.</p> <p>Review of the care plan, dated 02/17/11, revealed the staff was to keep the call light within reach and assist with transfers as need.</p> <p>Interview with CNA #14, on 05/26/15 at 10:15 AM, revealed Unsampled Resident H did not use the call light very often. He stated the resident was very independent and would tell him, he/she would let the CNA know if he/she needed help. The CNA stated he performed frequent checks on the resident because he/she had a history of falling with unassisted transfers. He stated the call light should be attached to the recliner and he thought the resident must have transferred from the bed to the chair without his knowledge or assistance.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/29/15 at 9:50 AM, revealed it was everyone's responsibility to check and ensure call lights were within reach for the residents. Each time the staff was in the resident's room they were to check the call lights. She stated the Unit Managers conducted rounds at the beginning of their shift and often throughout the day. The ADON stated she conducted frequent rounds</p>	F 246			



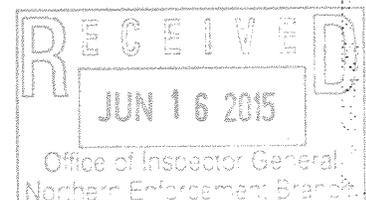
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F 246 F 282 SS=E	Continued From page 23 throughout the building and several times during her shift. She stated she would check to make sure call lights were within reach of the residents during her rounds. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement interventions outlined on the comprehensive care plan of three (3) of eight (8) sampled residents (Residents #2, 3, and 4) and three (3) of eighteen (18) unsampled residents (Unsampled Residents H, J and K). The facility staff failed to apply heel protectors as ordered and care planned to Resident #2's heels. The facility staff failed to perform indwelling catheter care each shift as care planned for Resident #3. The facility staff failed to ensure call lights were in reach at all times as care planned for Resident #4, and Unsampled Residents H, J, and K. The findings include: According to a fax received from the Assistant Director of Nursing (ADON) on 05/29/15 at 11:07 AM, revealed the facility utilized the Resident Assessment Instrument (RAI) process for their policy on care plans,	F 246 F 282	F 282 1. Residents identified were observed to ensure call light was in reach, heel lift boots were applied per care plan and Foley Catheter care was completed per care plan. 2. Walking rounds were completed 06/02/2015 to ensure Call lights were within reach, heel lift boots were in place per Care Plan and Foley Catheter Care was being provided per Care Plan. Certified Nurse's Assistant's assignment sheets were reviewed to ensure accuracy of resident information. 3. Nursing Staff were educated on following Care Plan and call light placement on 06/03/2015. Nursing staff were educated on Foley Catheter Care on 05/22/2015 and 05/26/2015. The Assistant Director of Nursing will complete daily (Monday through Friday) audits of Call Light placement and heel lift boot placement daily (Monday through Friday) for 2 weeks beginning 06/02/2015, weekly for 4 weeks beginning 06/17/2015 and monthly for 3 months beginning 07/17/2015. Results will be reported to Quality Assurance Committee in October 2015. A template was created and implemented for Certified Nurse's Assistant's to sign and attest that Foley Catheter care was completed per Resident care plan.	Completion by: 06/27/2015

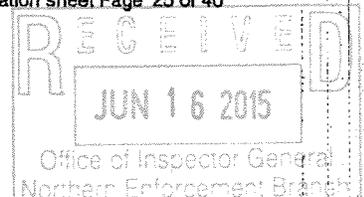


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F 282	Continued From page 24 1. Observation of Resident #4 on 05/21/15 at 8:05 AM, revealed the resident was laying in bed on his/her back with the call light attached to the code alarm on the wall. The staff exited the room and did not put the call light in reach. Review of the care plan, dated 01/30/15, revealed Resident #4 was at risk for falls and one of the interventions was to keep frequently used items, especially the call light, within reach at all times. 2. Observation of Unsampled Resident J, on 05/20/15 at 2:50 PM and 3:50 PM, revealed the resident was laying in bed on their back. The call light was attached to the code alarm on the wall and not within the resident's reach. When interviewed the resident shook his/her head no that he/she could not reach the call light. Observation, on 05/21/15 at 1:23 PM, revealed the resident was laying in bed with the call light attached to the code alarm on the wall. Review of the care plan, dated 05/02/12 and revised on March 2015, revealed the resident was at risk for falls and one of the interventions was to keep frequently used items, including the call light, within reach at all times. Interview with CNA #10, on 05/21/15 at 1:30 PM, revealed the call light should be within reach and she said she was coming back to put the call light within the resident's reach. 3. Observation of Unsampled Resident K, on 05/20/12 at 2:50 PM and 3:50 PM, revealed the resident was laying in bed on the left side, resting quietly. The call light was attached to the code alarm on the wall and not within the resident's	F 282	4. The Assistant Director of Nursing will complete daily (Monday through Friday) audits of Call light placement and Heel lift boot placement daily (Monday through Friday) for 2 weeks beginning 06/02/2015, weekly for 4 weeks beginning 06/17/2015, and monthly for 3 months beginning 07/17/2015. Results will be reported to Quality Assurance Committee in October 2015. Assistant Director of Nursing will audit new admissions and new physician orders for Foley Catheter use to ensure documentation template was initiated and signed daily for 2 weeks, weekly for 4 weeks, and monthly for 1 year. Results of audits will be reported in Quality Assurance Meetings quarterly for 1 year.	Completion by: 06/27/2015

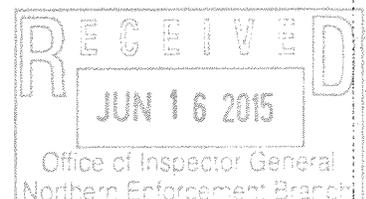


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F 282	<p>Continued From page 25</p> <p>reach. Observation on 05/21/15 at 1:23 PM, revealed the resident was laying in the bed and the call light was attached to the code alarm on the wall.</p> <p>Review of the care plan, dated 04/06/15, revealed the resident was at risk for falls and one of the interventions was to keep frequently used items within reach at all times.</p> <p>Interview with CNA #10, on 05/20/15 at 2:50 PM, revealed Resident K did not use the call light and she would just listen for him/her to scream. The CNA revealed when the resident screamed that meant he/she needed something and she would assist them.</p> <p>Interview with the West Wing Unit Manager, on 05/20/15 at 3:15 PM, revealed the call light should be within reach of the resident and if it was up on the code alarm on the wall it would not be. The Unit Manager stated if the resident could not reach the call light it would put them at risk for falling out of bed, trying to reach it. She stated if the resident was choking, thirsty, or needed something, they would not be able to let their needs be known if the call light was out of their reach.</p> <p>Interview with the ADON, on 05/26/15 at 3:50 PM, revealed if the care plan had an intervention for the call light to be within reach, then the call light should be accessible to the residents.</p> <p>4. Observation, on 05/20/15 at 3:55 PM, revealed Resident #2 was sitting up in a wheelchair (w/c) in a common area on the unit. A Kerlix bandage was observed on the resident's left foot and a sock on the right foot. At 5:09 PM, the resident was</p>	F 282		



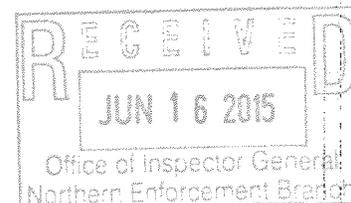
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F 282	<p>Continued From page 26</p> <p>observed in the dining room with bilateral heel protectors (Medi boots) applied. Interview with the resident revealed the staff had put the boots on a few minutes ago. The resident stated the boots were too little and they were not what he/she wore before. At 5:25 PM, the resident was observed in a w/c with the bilateral heel protectors removed and a soft-blue Lift boot was on the left foot. The Lift boot went from the resident's left foot to the knee. Interview with the resident revealed this was the boot he/she normally wore.</p> <p>Review of the clinical record revealed the facility re-admitted the resident from the local hospital on 03/21/15 after treatment for Pneumonia and Sepsis. Review of the admission orders, also dated 03/21/15, revealed the physician had ordered Prevalon boots to bilateral heels at all times when in bed and a Lift boot to the left foot at all times. Review of the May physician orders revealed the same orders for the boots. The clinical record revealed on 03/23/15, the wound clinic assessed the resident's left heel and documented a Stage 3 Diabetic Ulcer and a treatment was ordered.</p> <p>Review of the skin care plan, dated 07/08/14 revealed the wound started as an unstageable pressure area on 10/06/14. To prevent further skin breakdown the facility implemented treatment according to physician orders. Review of the Certified Nurse Aide care plans, not dated, revealed instructions to apply the Prevalon boots to both feet when in bed. The Heel Lift boot to the left foot at all times.</p> <p>Observation of Activity of Daily Living (ADL) care that included: peri-care, dressing, and sponge</p>	F 282		

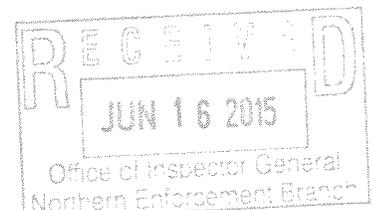


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F 282	<p>Continued From page 27</p> <p>bath, on 05/21/15 at 9:36 AM, revealed the resident was in bed with the Lift boot applied to the left foot. The Prevalon boots were not on the resident's feet according to the physician's orders and care plan. One boot was in the resident's w/c and the other one was located on top of the night stand.</p> <p>Interview with CNA #1, on 05/21/15 at 9:41 AM, revealed the resident was supposed to wear the Prevalon boots in bed and the Lift boot when up in the w/c. She did not know why the resident had the Lift boot on instead of the Prevalon boots, she supposed the night shift staff had not removed the Lift boot last night. She stated she had not noticed before because she did not deliver the resident's breakfast tray and had not provided ADL care yet.</p> <p>Interview with the West Wing Unit Manager, on 05/21/15 at 11:50 PM, revealed the resident was supposed to wear the Prevalon boots when in bed and the Lift boot when up in the w/c. She revealed she found the Lift boot yesterday in the resident's closet and applied the boot. She stated there were instructions on the CNA care plans which boots are suppose to be applied and when. She said she conducted round of the unit daily to monitor for devices to ensure they are applied according to the care plan and physician orders. She stated she reviewed the CNA care plans a couple times a week to ensure they reflected any changes with the residents.</p> <p>5. Review of Unsampled Resident H's clinical record revealed the facility admitted the resident on 05/12/15 with a history of falling. The resident was transferred from the Personal Care Home (PCH) Unit because of a decline in ADLs and</p>	F 282		

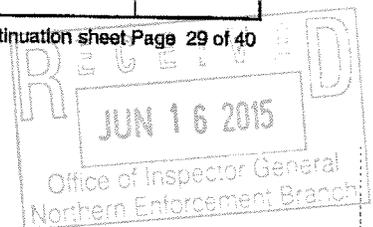


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F 282	<p>Continued From page 28</p> <p>falls. Review of the admission assessment, dated 05/19/15, revealed the facility assessed the resident to be at high risk for falls related to a history of falling. The resident's BIMS score was a thirteen (13) out of possible fifteen (15) which meant the resident was interviewable and the facility assessed the resident to require limited assist of one for bed mobility and transfers. The facility identified the resident's balance was not steady when the resident moved from seated to a standing position. Review of the Care Assessment Area (CAA) dated 05/19/15, revealed the resident had a history of falls related to unassisted transfers. The CAA stated the resident fell when attempting to transfer without staff assistance from the chair.</p> <p>Review of the care plan, dated 02/17/11, revealed the staff was to keep the call light within reach and assist with transfers as need.</p> <p>6. Observation of Unsampled Resident H, on 05/26/15 at 9:19 AM, revealed the resident was sitting up in a recliner that was positioned at least three (3) feet from the bed. The call light cord was wrapped around the side rail out of the reach of the resident. Interview with the resident during the 9:19 AM observation revealed he/she would transfer themselves if he/she needed to get into bed or use the call light.</p> <p>Interview with CNA #14, on 05/26/15 at 10:15 AM, revealed Unsampled Resident H did not use the call light very often. He stated the resident was very independent and would tell him, he/she would let the CNA know if he/she needed help. The CNA stated he performed frequent checks on the resident because he/she had a history of</p>	F 282		

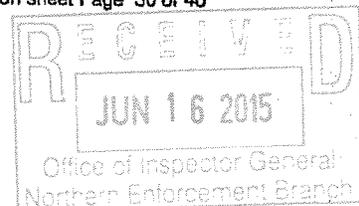


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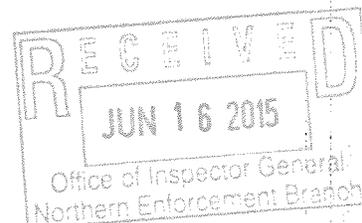
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F 282	<p>Continued From page 29</p> <p>falling with unassisted transfers. He stated the call light should be attached to the recliner and he thought the resident must have transferred from the bed to the chair without his knowledge or assistance.</p> <p>7. Review of Resident #3's clinical record revealed the facility admitted the resident on 09/15/14 with diagnoses of Abnormality of Gait, Paranoid Schizophrenia, Personal History of Fall, Muscle Weakness-General, Lack of Coordination, Difficulty Walking, Urinary Retention. Review of the quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed the facility conducted a BIMS with a score of eleven (11) out of possible fifteen (15) indicating the resident was interviewable at the time of the assessment.</p> <p>Review of the Care Plan pertaining to Resident #3's indwelling catheter, dated 10/14/14, revealed nursing staff would provide catheter care each shift and as needed.</p> <p>Review of the May CNA care plan revealed no instructions to provide catheter care every shift.</p> <p>Observation of Resident #3, on 05/20/15 at 3:52 PM, revealed an indwelling catheter to a drainage bag.</p> <p>Interview with Resident #3, on 5/20/15 at 3:52 and 05/21/15 at 8:05 AM, revealed the resident came to the facility from the hospital with an indwelling catheter. The resident stated the CNAs would complete catheter care most mornings and sometimes in the evenings. However, the resident stated he/she would have to ask the staff to clean the catheter because it itched at the site</p>	F 282		



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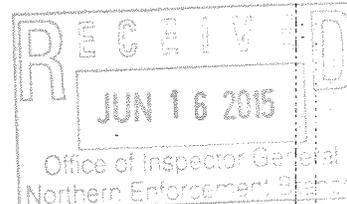
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F 282	<p>Continued From page 30 of the catheter at night if it was not cleaned.</p> <p>Review of the May 2015 Treatment Administration Record (TAR) revealed catheter care was to be provided each shift, 1st, 2nd, and 3rd shifts. The May TAR, from May 1 to May 20, 2015, revealed there were four (4) blanks without staff initials under the section for catheter care every shift and PRN. The record for April 2015 contained five (5) blanks without staff initials.</p> <p>Interview with RN #1, on 05/21/15 at 9:44 AM, revealed nursing staff should have provided catheter care to Resident #3 each shift. The RN stated catheter care included draining the catheter and giving perl care to the resident. The RN stated the CNAs completed this task in the mornings when they get the resident dressed.</p> <p>Interview with CNA #4, on 05/21/15 at 1:20 PM, revealed she completed an in-service and a skills check off last month related to catheter care. The CNA stated she completed catheter care when getting the resident up in the morning and when laying the resident down at the end of the shift. The CNA stated she did not know what the care plan stated to do for catheter care. The CNA also stated she documented in the Kiosk how much fluid and if anything was abnormal. However, there was no place to document when catheter care had been completed in the Kiosk. The CNA stated she did not report she completed the care to the nurse unless there was something unusual. Sometimes the nurse would ask if catheter care had been completed.</p> <p>Interview with the West Wing Unit Manager, on 05/21/15 at 2:15 PM, revealed the nurses were responsible for ensuring the CNAs completed</p>	F 282		



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F 282	Continued From page 31 catheter care as care planned. The nurses were supposed to ask the CNAs if they completed the catheter care and then document. The Unit Manager stated catheter care could be completed by a nurse or CNA once per shift. She stated if catheter care was not completed after bowel movements and once per shift, the resident would be at increased risk for Urinary Tract Infections. Interview with the Director of Nursing, on 05/21/15 at 3:07 PM, revealed nurses should be actively involved with resident care including catheter care. She stated the nurses and aides should communicate and inform each other when catheter care was provided. She stated she had not looked at the CNA care plans and did not realize the care plans gave no instructions for catheter care. She said catheter care was included in the facility's infection control training because if the catheter care was not provided, the resident would be at risk for Urinary Tract Infections.	F 282			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration	F 322	F 322 1. 05/21/2015 LPN #1 performed G-Tube placement and residual check on Resident #2 after being informed of failure to complete required tasks. LPN #1, an agency employee, verbalized and demonstrated competency with the procedure. 2. In-service for Nurses was completed on 05/22/2015 to re-educate nurses that placement and residual checks are required before meds or feedings are administered via a G-tube. 3. Nurses will be required to complete return demonstration competency regarding checking placement and residual on a G-tube by 06/26/2015.	Completion by: 06/27/2015	

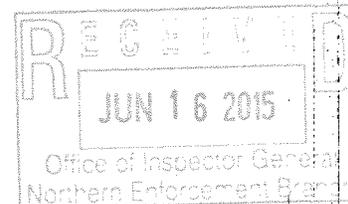


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F 322	<p>Continued From page 32 pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's reference manual, it was determined the facility failed to check for placement and gastric residual prior to medication administration for one (1) of two (2) sampled residents with a Gastrostomy tube (G-tube) out of total sample of (8) eight residents. Resident #2.</p> <p>The findings include:</p> <p>The facility used the Clinical Nursing Skills and Techniques reference book, Eighth Edition, for their policy on Enteral Nutrition and Administering Medications through an Enteral Feeding Tube. Review of the references provided by the facility revealed Chapter 31, pages 500-504 revealed the nurse should always verify correct placement of the feeding tube before administering medications. In addition, the manual instructed the nurse to check for gastric residual volume by flushing the tube with air and pulling back slowly to aspirate gastric contents.</p> <p>Observation of License Practice Nurse (LPN) #1 administering a medication through Resident #2's G-tube, on 05/21/15 at 8:21 AM, revealed the</p>	F 322	<p>Nurse's will be randomly observed for return-demonstration competency on checking G-Tube placement and residual monthly for 3 months.</p> <p>4. Nurses will be randomly observed for return-demonstration competency monthly for 3 months. Results of competencies will be reported in Quality Assurance Committee during quarterly meeting in October 2015.</p>	Completion by: 06/27/2015

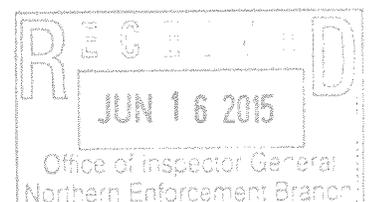


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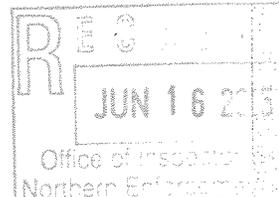
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F 322	<p>Continued From page 33</p> <p>nurse did not bring a stethoscope into the resident's room. There was no tube feeding infusing at the time of the medication administration. The medication was crushed and mixed with water in a small plastic cup. The nurse put on a clean pair of gloves and flushed the G-tube with thirty (30) Milliliters (ml) of water prior to medication administration. The medication was administered through the G-tube and then the nurse flushed the tube with thirty (30) ml of water. The nurse failed to check for placement of the tube prior to the medication administration and did not check for gastric residual volume.</p> <p>Interview with LPN #1, on 05/21/15 at 8:29 AM, revealed she thought she had checked for placement when she flushed the G-tube with water. She stated if you pull back and there are bubbles in the tube, that meant the tube was in the correct position. She validated she did not check placement of the tube via auscultation because she had forgotten her stethoscope. She stated she did not check for gastric residual because when she picked up the G-tube she could see there was no tube feeding in the tube. She stated she only looked at the tube and she normally did not check for gastric residual by using a syringe to withdraw stomach content. The nurse stated she worked through the agency for the facility and had not attended any inservice education related to administering medications through an Enteral Feeding Tube. She did not know if the facility had a policy regarding that topic, but stated she was taught in nursing school to check for placement with air using a stethoscope prior to administering any medications. She stated she was taught to check for residual with a syringe not just look at the tubing.</p>	F 322		



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F 322	Continued From page 34 Interview with the West Unit Manager, on 05/21/15 at 11:50 PM, revealed a nurse was supposed to check placement of a G-tube and residual each time a medication was given through the G-tube. She stated the instructions were on the Medication Administration Record (MAR) for the nurse to follow. She stated to her knowledge the facility had not provided education to agency nurses on how to administer medication through a G-tube. She stated the nurses received that training in nursing school and she would expect the nurse to follow the proper protocols they were taught. Review of Resident #2's clinical record revealed the facility admitted the resident on 03/21/15 with diagnoses that included Aspiration Pneumonia with a recent Cerebrovascular Accident (CVA). The G-tube was placed in the hospital prior to the resident's admission. The clinical record revealed a Speech Therapist was working with the resident and the resident was now receiving a mechanical soft diet with nectar thick liquids. Review of a telephone order, dated 05/18/15, revealed the G-tube feedings would be administered from 6:00 PM to 6:00 AM via pump at eighty-five (85) ml per hour. Review of Resident #2's May Medication Orders revealed instructions to check residual at each medication pass and to check the placement of the G-tube. Review of the MAR for May revealed Resident #2's G-tube was to be checked for placement and residual at each medication pass. Review of the Enteral Record revealed instructions to the nurse to check the G-tube placement prior to medications and water flushes. The record instructed the nurse to check for	F 322			



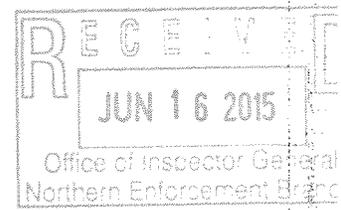
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F 322	Continued From page 35 residual before medications or water flushes are administered. The G-tube was to be flushed with thirty (30) ml of water before and after medications were administered through the G-tube.	F 322		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to document care provided and abuse allegations for six (6) of the eight (8) sampled residents (Resident #1, #2, #3, #4, #7 and #8). The facility staff failed to initial catheter care on the Treatment Administration Record (TAR) for Resident #1, Resident #3, and Resident #4. The facility staff failed to document allegations of abuse for Resident #7 and Resident #8. The facility staff failed to initial on the Medication	F 514	F 514 1. Medical Records for residents identified were reviewed by Nursing Unit Managers to ensure documentation was completed, accurate and signed. 2. Audit was completed of MARS/TARS to identify missing documentation for other residents in facility. 3. Education on importance of complete, accurate and timely documentation was completed for nursing staff on 05/26/2015 and 06/01/2015. Nurses were instructed to review off-going nurses documentation including MARS/TARS for accuracy & completion at shift change. Nurses will complete this cross check review every shift for 2 weeks. Unit Manager or Assistant Unit Manager will audit documentation including MARS/TARS for accuracy and completion weekly for 4 weeks then monthly for 1 year. 4. Unit Manager or Assistant Unit Manager will audit documentation including MARS/TARS for completion and accuracy weekly for 4 weeks then monthly for 1 year. Results of audits will be reported in Quality Assurance Committee meetings quarterly for 1 year.	Completion by: 06/27/2015



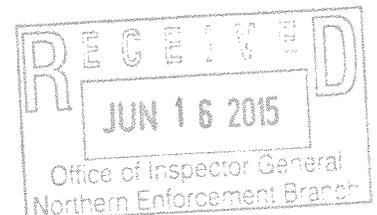
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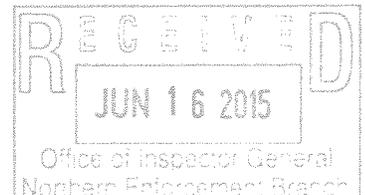
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F 514	<p>Continued From page 36 Administration Record (MAR) Resident #2's gastrostomy (G-tube) medications.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Clinical Record Documentation Guidelines, effective date of 02/20/12, revealed the facility was to maintain a clinical record on each resident that was complete, accurately documented, accessible and organized. The policy revealed the complete clinical record should contain an accurate and functional representation of the experience of the resident in the facility. Review of the policy revealed medication and treatment administration should be documented, injuries, unusual occurrences and incidents.</p> <p>1. Review of Resident #4's clinical record revealed an order, dated 03/26/15, for an indwelling catheter. Review of the April 2015 TAR revealed catheter care was to be provided every shift and as needed. however, the TAR revealed there were many days not initialed to indicate the catheter care was done. April 15-16 2015 and April 22-30 2015, on various shifts, had no documented evidence catheter care was provided. Continued review revealed there wasn't a May 2015 TAR in the treatment book.</p> <p>Interview with the Director of Nursing, on 05/21/15 at 5:15 PM, revealed there was no TAR for Resident #4 for May 2015. A May TAR had been placed in the resident's treatment book; however, there was no documented evidence catheter care had been provided every shift from 05/01/15 through 05/20/15 for the first, second or third shift. In addition, there were no staff initials</p>	F 514		



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F 514	<p>Continued From page 37</p> <p>to indicate the catheter care had been provided on the second shift from 05/21/15 through 05/25/15.</p> <p>2. Review of the clinical record for Resident #1 revealed a physician order dated 05/08/15 for an indwelling catheter to be placed related to Urinary Retention. Review of the May 2015 TAR revealed catheter care was to be provided every shift and as needed. Continued review of the May TAR revealed no staff initials to indicate catheter care had been provided on May 6, 2015 through May 11, 2015.</p> <p>Interview with the East Wing Unit Manager, on 05/26/15 at 1:35 PM revealed the TAR was supposed to be initialed by the nurses when the catheter care had been done. If the TAR was not initialed, that indicated the catheter care was not done.</p> <p>3. Review of the clinical record of Resident #2 revealed a Gastrostomy tube (G-tube) was placed on 03/19/15 while the resident was in the hospital. The clinical record revealed the tube feeding had been changed several times with the most recent physician order for the tube feeding to be Glucerna 1.5 to infuse via pump at 85 milliliters (ml) per hour from 6:00 PM to 6:00 AM. Review of the March, April, and May Enteral Record revealed multiple blanks in the record where no staff initialed the tube feeding was provided. In addition, there were multiple blanks on the March, April, and May Enteral Record without staff initials to indicate the G-tube was checked for placement, residual, and flushed.</p> <p>Interview with the West Unit Manager, on 05/21/15 at 11:50 PM, revealed the nurses are</p>	F 514			



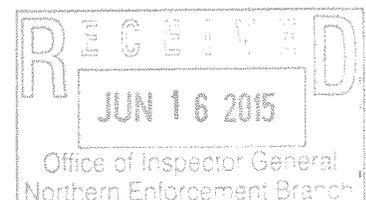
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F 514	<p>Continued From page 38</p> <p>supposed to initial to indicate the tube feeding was administered. If there are blanks without staff initials, there was no evidence the nurse provided the tube feeding and the same goes for the placement and water flushes.</p> <p>4. Review of the clinical record for Resident #7 revealed no document evidence of the allegation of verbal abuse the resident alleged occurred about a month ago. Refer to F225 and F226.</p> <p>5. Review of the closed clinical record or Resident #8 revealed no documentation of the reported allegation of abuse from the resident around 11/15/14. The facility placed the information on a Grievance form, but failed to document the resident's physical and emotional status during the allegation. Refer to F225 and F226.</p> <p>6. Review of the clinical record for Resident #3 revealed the facility admitted Resident #3 on 09/15/14 with diagnoses of Abnormality of Gait, Paranoid Schizophrenia, Personal History of Fall, Muscle Weakness-General, Lack of Coordination, Difficulty Walking, and Urinary Retention. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/09/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) exam with a score of eleven (11) out of possible fifteen (15) indicating the resident was interviewable at the time of the assessment.</p> <p>Review of the Physician's Orders for, 05/01/15 through 05/31/15, revealed the physician ordered catheter care to be provided every shift. Review of the Care Plan, dated 10/14/14, revealed nursing staff would provide catheter care each shift and as needed.</p>	F 514		



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2015
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NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
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F 514	<p>Continued From page 39</p> <p>Review of the May 2015 TAR revealed catheter care was to be provided each shift, 1st, 2nd, and 3rd shifts. The May TAR, from May 1 to May 20, revealed there were four (4) blanks without staff initials under the section for catheter care every shift and PRN. The record for April 2015 contained five (5) blanks without staff initials.</p> <p>Interview with the East Wing Unit Manager, on 05/26/15 at 11:30 AM, revealed all nurses were responsible to initial when the catheter care was provided. If it was blank and not signed, it indicated the care was not done. She stated the CNAs actually performed the catheter care and the nurses just initialed on the TAR the task was completed. The nurse should ask the CNA if the catheter care was completed. She stated if the staff did not do catheter care, it increased the risk for Urinary Tract Infections. She stated she reminded the staff to document on the TAR and she was auditing weekly for blanks on the TAR and MAR, but recently had not been done. She stated she would randomly audit a record, but did not look at every record. She stated she had talked about the lack of documentation during staff meetings, but continued to see a problems.</p> <p>Interview with the Assistant Unit Manager for the East Wing, on 05/26/15 at 2:05 PM, revealed she was checking the MAR and TAR daily to ensure care was documented in the record. However, she had been off on maternity leave and did not know who had checked the records in her absent.</p>	F 514		

