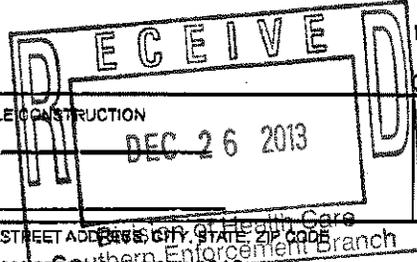


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185150	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 12/03/2013
NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERSONS WALKEN ROAD HINDMAN, KY 41822	
(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 An abbreviated standard survey (KY20987) was conducted on 12/03/13. The complaint was substantiated with deficient practice identified at "D" level.	F 000	See Attached	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruby Pignone - Administrator TITLE: Administrator (X6) DATE: 12/26/13

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	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on interview, and a review of medical records, the facility's Abuse Policy, and the facility's investigation, it was determined the facility to ensure an allegation of abuse was immediately reported to the Administrator and/or administrative staff. The facility also failed to interview staff that had worked the day of the alleged incident, failed to interview residents being cared for by the alleged perpetrator, and failed to assess non-interviewable residents for injuries or increased behaviors for the day of the alleged incident. The findings include: Review of the facility's "Abuse Policy," revised December 2011, revealed in the "Reporting Policy and Procedures" section, "All allegations involving mistreatment, neglect, or abuse, including injuries of an unknown source, or misappropriation of resident property will be reported immediately to the Director of Nursing and/or the Administrator of the facility and to other officials in accordance with State law, including the state survey and certification agency." Continued review of the policy revealed personnel on the 7:00 AM to 3:00 PM shift were to report any allegations directly to the Unit Supervisor; the Unit Supervisor would report the allegation to the Director of Nursing (DON); and the DON would report the allegation	F 225			

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F 225	Continued From page 2 to the Administrator. Review of the "Abuse and/or Resident Neglect Investigation" section of the policy revealed when a suspected incident of resident abuse was reported, the Administrator or DON would appoint a representative to investigate the incident. Further review revealed, "A thorough investigation shall be completed." The policy revealed staff could document the results of the investigation in an "Investigative Summary" report format or on a "Resident Abuse Investigation Report Form." Review of additional undated information provided by the facility entitled "Guidance for person conducting investigation" revealed the facility's investigation would consist of: a) An interview with the person reporting the incident, b) Statement of the resident's physical condition, c) Interviews with any witness to the incident, d) Interview with the resident, e) Review of the resident's medical record, f) Interviews with staff members (on all shifts) having contact with the resident during the period of the alleged incident, g) Interview the resident's roommate, h) Interviews with other residents in which the employee provided care to, and i) Review of all circumstances surrounding the incident. Review of the facility's investigation of an abuse allegation revealed on 11/14/13 at 12:30 PM, State Registered Nursing Aide (SRNA) #1 reported to Registered Nurse (RN) #1 that prior to the lunch meal on 11/11/13, she witnessed SRNA #2 cursing and roughly handling Resident #1. The investigation revealed the facility suspended SRNA #2 on 11/14/13 pending the results of the investigation and reported the allegation to Resident #1's physician, responsible party, and the appropriate state agencies. Documentation	F 225		

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F 225	Continued From page 3 revealed RNs #1 and #2 conducted the investigation of the allegation on 11/14/13 but were unable to contact the SRNA to interview the alleged perpetrator, SRNA #2, and concluded the investigation on 11/14/13 (the same day the allegation was reported). Based on the review of the facility's investigation report by RN #2 and the Administrator's Summary documented by the Administrator, both dated 11/14/13, the facility failed to interview SRNA #2 (the alleged perpetrator), Resident #1, the resident's roommate, other residents for which SRNA #2 provided care, the person that reported the incident, and staff members (on all shifts) that had contact with the resident during the period of the alleged incident. Documentation also revealed the facility failed to obtain a statement and/or assessment of the resident's physical condition at the time the allegation was reported and failed to review the resident's medical record and document the circumstances that surrounded the incident as indicated in the facility's policy. In addition, the facility failed to document an assessment of the resident, and/or other residents, for evidence of injuries or changes in their behaviors that could indicate abuse had occurred. Interview on 12/03/13 at 3:10 PM with State Registered Nurse Aide (SRNA) #1 revealed on 11/11/13 SRNA #2 requested SRNA #1 to assist with incontinence care for Resident #1. SRNA #1 stated they had almost completed the incontinence care and Resident #1 became incontinent again and, as a result, they had to immediately provide incontinence care again. At that time, SRNA #1 stated SRNA #2 stated, "Oh my f---ing God," and left the room to gather more supplies. SRNA #1 also stated when SRNA #2	F 225			

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F 226	<p>Continued From page 4</p> <p>returned to Resident #1's room, SRNA #2 told the resident to "roll over," and when the resident did not roll, SRNA #2 "pushed" the resident roughly. According to SRNA #1, at that time, Resident #1 swung her arm back, hit SRNA #2 in the face, and SRNA #2 said, "Oh damn, she got me." The interview revealed SRNA #1 did not report the allegation because the Administrator and DON were not at the facility; they were out of town at a convention and SRNA #1 thought she was required to report the incident directly to the Administrator or DON. The SRNA stated when she returned to work on 11/14/13, she decided to report the allegation to RN #1.</p> <p>Interview on 12/03/13 at 2:30 PM with RN #1 confirmed SRNA #1 reported to her on 11/14/13 that on 11/11/13, while SRNA #2 provided direct care to Resident #1, she observed SRNA #2 curse at Resident #1 and handle the resident roughly. RN #1 stated she notified RN #2 of the allegation and both nurses conducted an investigation. RN #1 stated she and RN #2 interviewed SRNA #1, and RN #2 notified Administration and the state agencies and completed the paperwork. RN #1 stated she discussed the allegation with Resident #1's responsible party. The interview revealed RNs #1 and #2 initiated in-services on abuse to staff working on 11/14/13 but did not interview the staff about the alleged incident. RN #1 stated Resident #1 did not have a roommate at the time of the report, and at the time of the allegation the roommate was non-interviewable, and Resident #1 was non-interviewable, therefore, an interview was not conducted with the resident. RN #1 stated, "I would have only interviewed other staff or residents if they were 'involved' in the allegation."</p>	F 225		

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F 225	Continued From page 5 Interview on 12/03/13 at 2:00 PM with RN #2 confirmed RN #1 informed her on 11/14/13 that SRNA #1 had reported that SRNA #2 had cursed and treated Resident #1 roughly on 11/11/13. RN #2 stated staff that worked on 11/14/13 had also worked on the date of the alleged incident on 11/11/13, and had been interviewed but, because they had not witnessed the alleged incident, the interviews were not documented. RN #2 also stated an interview was attempted with Resident #1 without success due to the resident's cognition but was not documented. In addition, RN #2 reported staff had conducted a skin assessment of Resident #1 on 11/14/13, and had not identified any concerns. According to RN #2, SRNA #1 received a verbal reprimand for not immediately reporting the allegation of abuse, and SRNA #2 was suspended and would not be allowed to return to work unless the investigation by the Department for Community Based Services (DCBS) determined the allegation to be unsubstantiated. A review of the facility's schedules for 11/11/13 and 11/14/13 revealed although the nurses on the schedule had worked both days, SRNA #1 was the only SRNA that worked the same hours on 11/11/13 and 11/14/13, and as a result, interviews had not been conducted with the staff that worked with Resident #1 and/or SRNA #2 on the day of the alleged incident (11/11/13). On the day of the investigation, 12/03/13, an interview was conducted by telephone with SRNA #2 at 1:35 PM. SRNA #2 confirmed she was suspended from employment on 11/14/13 related to an allegation concerning Resident #1. SRNA #2 acknowledged she had said, "Damn she hit me in the face," when Resident #1 hit the SRNA	F 225			

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F 225	<p>Continued From page 6</p> <p>when she and SRNA #1 provided incontinence care on 11/11/13. However, SRNA #2 denied that she had cursed at the resident or had been rough with Resident #1 when she provided care to the resident. A review of the personnel file of SRNA #2 revealed the facility had hired the SRNA on 03/11/13 and had submitted a request for a criminal background check of the employee on 03/06/13. Continued review of the personnel file revealed SRNA #2 had no reprimands for abuse or neglect. In addition, documentation revealed the facility had trained SRNA #2 on the facility's policy related to abuse upon hire.</p> <p>An interview was conducted with Resident #3 on 12/03/13 at 12:10 PM and revealed she had witnessed staff providing care to the resident's roommate (an unsampled resident) in a rough manner; however, Resident #3 was unable to recall the date or the name of the facility staff.</p> <p>Interview on 12/03/13 at 3:25 PM with the DON revealed the facility provided education to the nurses related to abuse and how to conduct an investigation during the orientation process at the time of employment. However, the interview revealed the facility's investigation process entitled "Guidance for person conducting investigation" was included in the nurses' orientation process but was not included in the annual in-services. The DON stated only the staff and residents involved in an allegation of abuse would have been interviewed during the course of an investigation of abuse.</p> <p>Interview on 12/03/13 at 4:50 PM with the Administrator revealed the nurse that received an allegation of abuse would conduct the investigation and notify the Administrative staff.</p>	F 225			

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F 225	Continued From page 7 The interview revealed the Administrator was responsible to ensure the investigation report was completed, that documentation was correct, and that in-services with staff were conducted. The Administrator confirmed she had been made aware of the allegation related to SRNA #2 and Resident #1, had reviewed the investigation, and acknowledged by signature that the investigation was complete. The Administrator stated the results of the facility's investigation were sent by "fax" to the appropriate state agencies.	F 225			

**Knott County Health & Rehabilitation Center
Abbreviated Survey Completed 12-03-13**

F 225

- 1. Resident #1 was protected during the investigation as the SRNA#1 was suspended immediately and eventually terminated from employment. Resident #1 was assessed for injuries and signs/symptoms of increased anxiety/agitation, with no identified concerns. Interviews were conducted with other staff members and residents as well to determine if any inappropriate behavior had been witnessed or occurred during the time of alleged incident, with no identified issues. These findings were documented and placed with the investigative report.**
- 2. All residents have been assessed and/or interviewed (if they were interviewable) to determine if any identifiable concerns/distress that may have resulted from inappropriate actions of staff. No concerns were identified.**
- 3. In-services were conducted on December 26, 2013 by Consultant Staff with Administrator & all Nursing Supervisory Staff. The in-service included review of the Abuse Policy and how to conduct a thorough investigation of any allegation or incident. The in-service specifically included timely reporting of allegations/incidents to Administration, actions that should be taken during the investigative process (including staff/resident interviews, assessment of non-interviewable residents for behaviors, etc). Information regarding documentation of the appropriate steps during the investigative process and completion of the report was also reviewed. An in-service will be conducted for all staff on December 27, 2013 by the Administrator and Director of Nursing to review the Abuse Policy, immediate reporting to direct supervisor/Administration, protecting the resident, assessment of a resident with appropriate documentation/physician notification, etc.**
- 4. CQI Committee, Administrator/DON will review every investigative report of any allegation of abuse/neglect during the weekly CQI meetings to ensure appropriate interviews with staff, residents, assessments, notifications, and actions were conducted timely and documented in the investigative report. These reviews will be conducted on a weekly basis for one quarter, then at least monthly thereafter. Any identified concern will be addressed & corrected immediately and will re-evaluated by the CQI Committee.**
- 5. Completion Date: 12-31-13**