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

PRINTED: 07/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 07/05/2012

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1705 STEVENS AVENUE
LOUISVILLE, KY 40205

(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 survey was conducted 07/03/12 through 07/05/12 to investigate KY18663. The Division of Health Care substantiated KY18663 with deficiencies cited.	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to protect one (1) of the three (3) sampled residents (Resident #1) from verbal abuse by not following the facility's policies. The findings include: Review of the facility's policy regarding Prevention and Reporting of Suspected Abuse and Neglect, not dated, revealed verbal abuse was oral, written or gestured language that willfully includes disparaging and derogatory terms to a resident or their families or within hearing distance, regardless of their age, ability to comprehend or disability. Prevention is implemented through, but is not limited to, an	F 223	F 223 1. On 6/30/12, housekeeper #2 was escorted out of the building by the house supervisor. Housekeeper #2 was subsequently terminated from her position based on discourteous treatment of a resident. Resident #1 was interviewed by psychiatric services and shows no signs or symptoms of distress or emotional upset related to the event. 2. All residents have the potential to be affected by staff actions. On 7/27/12 the administrator and assistant director of nursing met with the administrative team which includes the director of maintenance, assistant director of therapy, housekeeping supervisor, health information manager, MDS coordinator,, social service directors, staff development coordinator, human resource director and business office manager to determine if any other residents were acting in a manner similar to resident #1, four residents were identified. The Interdisciplinary team (*nursing, social services, unit managers)* will review these four resident to validate that each of these residents have a behavior assessment, team review and appropriate care plan on or before 7/30/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Hamilton
TITLE: Administrator
(X6) DATE: 7-27-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 223	Continued From page 1 analysis of: the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as resident with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care. Observation and interview with Resident #1, on 07/03/12 at 9:35 AM, revealed the resident walking down the hall unassisted, without the use of his/her sight cane. The resident stated he/she was coming back from a smoke break. The resident revealed being legally blind and residing at the facility for five or six weeks. The resident repeatedly expressed a desire to leave the facility and stated social services was assisting with placement. Upon returning to room, when asked about what had occurred the previous weekend, the resident revealed Housekeeper #2 accused the resident of directing foul language to the housekeeper. The resident revealed he/she was talking to the roommate about the housekeeper, not to the housekeeper. Resident #1 stated the housekeeper was telling the staff he/she would not go back into the resident's room. The resident fell to his/her side laughing out loud and then stated the housekeeper was using foul language out in the hall. The resident stated he/she told the roommate the housekeeper was lazy. The resident stated the housekeeper said she was going to black my eye, again the resident started to laugh and slap his/her knee. The resident thought the housekeeper's reaction was funny. The resident expressed being mad about not being able to leave for an overnight outing.	F 223	3. The administrator and director of nursing reviewed the policy and procedure for preventing abuse and neglect on 7/5/12, no changes to the policy were required. On 7/5/12 education regarding abuse and neglect was provided to the housekeeping staff by the regional nurse. This education included appropriate conduct and reporting concerns with resident behaviors through the immediate action plan process. All staff receive education regarding abuse and neglect, reporting resident behaviors and the behavior management program during orientation and annually. All staff are responsible for appropriate treatment of residents and reporting resident behaviors through the behavior management program. On 7/27/12 the administrator and regional nurse provided education to administrative team members regarding interviewing staff through the QA process and provided team members education on how to complete the QA audit tool on resident protection and behavior intervention. 4. Administrative staff will complete resident protection and behavior intervention audits for a minimum of four months to validate that line staff	

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F 223	Continued From page 2 The resident indicated not being mad at the housekeeper and stated she should have just gone on about her business after I said my peace. When asked for clarification about what was said the resident refused to respond. Review of the clinical record for Resident #1 revealed an admission date of 05/31/12 with admission diagnoses of a Stroke, Obstructive Pulmonary Disease, Legally Blind, Alcohol Abuse, Oral Cancer, and Homelessness. The facility assessed the resident on the Minimum Data Set (MDS), dated 06/13/12, with a cognition score of fourteen (14) meaning the resident was cognitively intact. Interview with Housekeeper #2, on 07/05/12 at 10:37 AM, revealed Resident #1 had started insulting her using derogatory names, calling her a black bitch and taking stuff from the housekeeping cart two (2) weeks prior to the incident on 06/30/12. The housekeeper stated telling the staff she did not want to go into the room due to the residents behavior, and therefore had other people clean the residents room. The housekeeper revealed this had only made the resident more angry and the behavior just continued. The housekeeper stated she did raise her voice and was upset after the resident called her a bitch and a whore in front of visitors; however, denied using foul language directed at the resident. Interview with Housekeeper #3, on 07/05/12 at 11:45 AM, revealed they were aware of housekeepers helping out on Resident #1's unit. The housekeeper revealed not being aware of any problems between the resident and	F 223	have a complete understanding of the behavior management program. (*The administrative team consists of the administrator, director of nursing, director of maintenance, director of therapy, activity director, housekeeping supervisor, MDS coordinators, social service directors, assistant director of nursing, staff development coordinator, human resource director and dietary manager, medical records, and business office manager.* The audit will determine if staff understand how to complete a behavior symptom sheet, document new or existing behaviors and understand how to deal with difficult residents using the behavior management program as well as reporting resident behaviors. Each administrative team member will be responsible for interviewing a minimum of six staff members a month to validate that staff members understand the process. The results of these audits will be submitted to the Quality Assurance and Assessment Committee monthly. The QA&A Committee will determine if additional education or auditing is	

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F 223	Continued From page 3 housekeeper #2, just thought the housekeeper needed help. Interview with Certified Nursing Assistant(CNA) #1, on 07/05/12 at 11:25 AM, revealed he/she was in anther resident's room when the verbal altercation occurred but did hear the yelling. The CNA revealed the resident was upset the housekeeper had not cleaned the room and the housekeeper was talking loudly at the nursing station. The CNA revealed the supervisor tried to calm the housekeeper down, then had the housekeeper leave the floor. The CNA revealed witnessing things before between the housekeeper and the resident. The CNA stated the resident would "Hunt" down the housekeeper and say things to her. The CNA revealed hearing the resident make a derogatory sexual comment to the housekeeper and it was then the housekeeper told the resident someone else would be cleaning the room, but the resident would not let it go. The CNA revealed not telling anyone what was witnessed because other staff had seen stuff too and knew the resident had a "bad" mouth. The CNA revealed she thought housekeeper #2 had told the housekeeping supervisor. Interview with Licensed Practical Nurse (LPN) #1, on 07/05/12 at 3:10 PM, revealed the LPN had heard Resident #1 yell and shout before, and that he/she wanted stuff immediately, but stated she did not work with the resident very often. Interview with LPN #3, on 07/05/12 at 3:20 PM, revealed when resident #1 arrived he/ she was very demanding, but that had improved. The LPN revealed the resident still curses and uses	F 223	required. (*For future reference the QA&A committee consists of the following team members. administrator, director of nursing, medical director and at least two of the following team members, director of maintenance, director of therapy, activity director, housekeeping supervisor, unit managers, MDS coordinators, social service directors, assistant director of nursing, staff development coordinator, human resource director and dietary manager and medical records and line staff.* 5. The facility alleges compliance on August 1, 2012.	

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F 223	Continued From page 4 foul language but she thinks it was more a joking manner, but then indicated maybe its just his/her personality. Interview with Registered Nurse (RN) #2, on 07/05/12 at 2:53 PM, revealed seeing Housekeeper #2 and Resident #1 yelling at each other in the hall on 6/30/12. The RN revealed the housekeeper bent over attempting to make contact with the resident who was sitting in a wheelchair. When the resident stood up the RN stated she put her hand in front of the housekeeper and told her to stop. The RN revealed the housekeeper continued to yell in the hall way and the supervisor had her leave the floor. The RN stated the resident said he/she was fine and immediately de-escalated as soon as the housekeeper was gone. Interview with the Unit Manager (UM), on 07/03/12 at 2:25 PM, revealed the resident had wanted to leave the facility for the whole weekend and became very upset when told he/she could not leave on 6/29/12. The UM revealed the resident was clapping his/her hands together, yelling and cursing at the desk and required redirection. The UM described the resident as typically being a "smarty", thinking it was funny, and could be socially inappropriate and make other residents mad with comments. When asked what was done about the behavior the UM revealed it was smoothed over. Interview with RN #1, on 07/05/12 at 9:30 AM, revealed Resident #1 was upset due to not being allowed out of the facility for the entire weekend. The RN revealed Housekeeper #2 stated the resident had called her several derogatory names	F 223		

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F 223	Continued From page 5 which the resident denied doing. Interview with the MDS coordinator, on 7/5/12 at 3:16 PM, revealed no one had ever reported any behavior, or use of foul language by Resident #1. Review of the Behavioral Referral and Symptom Incident Record revealed the form was not filled out until 6/30/12 after the verbal altercation with staff. Interview with the Housekeeping Supervisor, on 07/05/12 at 11:00 AM, revealed housekeeper #2 did not report having problems with Resident #1. The Housekeeping Supervisor revealed all staff are trained on abuse and told if there are problems to tell the nursing staff. The Housekeeping Supervisor reported staff are told to step away and get someone or go take a break when things get bad. The Housekeeping Supervisor revealed if she had known she would have reassigned housekeeper #2. Interview with the Director of Nursing (DON), on 07/05/12 at 2:03 PM, revealed she was not aware of any issues between Resident #1 and Housekeeper #2. The DON revealed the resident can become upset, but we have redirected him or reeducated him on those issues. The DON revealed the housekeeper had just completed new employee orientation in February. The DON revealed staff had informed her multiple times that the resident got angry because he/she could not go out overnight, but had never heard of the resident saying anything inappropriate. The DON revealed discharge planning had been difficult and they were trying to relieve some of the residents frustrations by finding safe housing.	F 223		

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F 223	Continued From page 6 The DON revealed she was not aware of the resident having a particular target for behavior.	F 223		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop a plan of care for supervision of behaviors for one (1) resident of the three (3) sampled residents. The facility failed to assess and develop a plan of care to address Resident #1's behaviors displayed toward staff which escalated into verbal abuse by a staff member.	F 279	F 279 1. On 6/30/12 a behavior symptom sheet was completed by a licensed nurse for resident #1's behaviors, including foul language towards staff. The interdisciplinary team met and reviewed this resident and updated his care plan. Resident #1 no longer resides at the facility based on his desire to discharge against medical advice. (*For future reference the interdisciplinary team consists of social services, unit managers, DON /and or ADON and as needed therapy)* 2. All residents are expected to have comprehensive care plans that include measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. On 7/27/12 the administrator and assistant director of nursing met with the administrative team which includes the director of maintenance, assistant director of therapy, housekeeping supervisor, MDS coordinator, social service directors, health information manager, staff development coordinator, and human resource director to determine if any other residents were acting in a manner similar to resident #1, four	

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DIVISION OF HEALTH CARE FACILITY INVESTIGATIONS

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F 279	Continued From page 7 The findings include: Review of the facility's policy regarding Behavior Management Program, undated, revealed the behavior management program is designed to address behavioral symptoms to reduce or eliminate these symptoms. The goal of the Behavior Management Program will take into consideration each individuals specific needs, honor everyone's rights and clarify responsibilities. The interdisciplinary team is responsible for assessing each resident. Caregivers will identify new symptoms, determine new interventions, implement the approaches and evaluate the effectiveness of the approaches. The Behavioral Symptom Referral/Incident Record is available at each nurse's station. Any employee in any department who witnesses behavioral symptoms can complete the form. Record review for Resident #1 revealed an admission date of 05/31/12 and diagnoses of Stroke, Legally Blind, and Alcohol Abuse. The MDS dated 06/13/12 did not indicate the presence of any behaviors. Review of the plan of care did not reveal any indication the resident displayed behaviors towards others until 06/30/12 after the verbal altercation with a staff member. Review of the Psychiatric Mental Status Exam, dated 06/04/12, revealed the resident was coherent, and logical with impaired insight and judgement; however, would benefit from treatment Observation of Resident #1, on 07/03/12 at 9:35 AM, revealed the resident was up and dressed,	F 279	other residents were identified.The Interdisciplinary team (*nursing, social services, unit managers)* will review these four resident to validate that each of these residents have a behavior assessment, team review and appropriate care plan on or before 7/30/12. 3. On 7/5/12 the director of nursing reviewed the RAI guidelines for completing and updating care plans. The regional nurse and assistant director of nursing initiated education to the care plan team on 7/27/12 elated to care plan requirements based on the RAI guidelines. The care plan team members consist of nursing, MDS coordinators, social services, activities, and dietary manager. Nursing and social services are expected to complete behavioral care plans as indicated for residents with behaviors. 4. Administrative staff will complete resident protection and behavior intervention audits for a minimum of four months to validate that team members have a complete understanding of the behavior management program. (*The administrative team consists of the administrator, director of nursing, director of maintenance, director of*	

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F 279	Continued From page 8 walking in the hallway without the use of his/her cane. Interview with Resident #1, at the time of the observation, revealed Housekeeper #2 accused the resident of directing foul language to her. The resident clarified he/she was talking to the roommate and not the housekeeper. When the housekeeper told the staff she would not going back into the room, the resident stated he fell to his/her side and started laughing. The resident then indicated the housekeeper used foul language in the hallway. The resident indicated the housekeeper was going to black his/her eye at which the resident started to laugh again. The resident thought the housekeepers reaction was funny and she should have gone on about her business after the resident had his/her say. The resident refused to specify what was actually said to the housekeeper. Interview with Housekeeper #2, on 07/05/12 at 10:37 AM, revealed Resident #1 had started insulting her using derogatory names calling her a black bitch. The resident had started about two weeks ago taking things out of the housekeeping cart. She stated she told nursing staff she did not want to go into the resident's room anymore due to the behaviors. This only made the resident more angry and the behaviors continued. After the resident called her a bitch and whore in front of visitors, she became upset and raised her voice. Interview with CNA #1, on 07/05/12 at 11:25 AM, revealed the resident would hunt down the housekeeper and say things to her. She heard the resident make derogatory sexual comments	F 279	*therapy, activity director, housekeeping supervisor, MDS coordinators, social service directors, assistant director of nursing, staff development coordinator, human resource director and dietary manager, medical records, and business office manager.)* The audit will determine if staff N 104understand how to complete a behavior symptom sheet, document new or existing behaviors and understand how to deal with difficult residents using the behavior management program. Each team member will be responsible for interviewing a minimum of six staff members a month to validate that staff members understand the process. The results of these audits will be submitted to the Quality Assurance and Assessment Committee monthly. The QA&A Committee will determine if additional education or auditing is required. 5. The facility alleges compliance on August 1, 2012.	

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F 279	Continued From page 9 to the housekeeper and it was then the housekeeper told the resident someone else would clean the room; however, the resident would not let it go. The CNA stated she did not report the behavior, as other staff had witnessed it also and knew the resident had a bad mouth. Interview with LPN #3, on 07/05/12 at 3:20 PM, revealed they were aware of the resident yelling and shouting and wanting stuff immediately. Interview with RN #2, on 07/05/12 at 2:53 PM, revealed she had to step between the housekeeper and the resident as the housekeeper was attempting to make contact with the resident and the resident stood from the wheelchair. When the housekeeper left the unit the situation de-escalated. Interview with the Unit Manager (UM), on 07/03/12 at 2:25 PM, revealed on 06/29/12 the resident was at the nurse's station clapping his hands, yelling and cursing requiring redirection by staff. The UM described the resident as being a smarty, thinking he/she was funny, and could be socially inappropriate and make other residents made with his/her comments also. The UM stated nothing was done regarding the behavior as it was just smoothed over. In addition, the behavior referral form was never completed. Interview with RN #1, on 070/05/12 at 9:30 AM, revealed the resident was known to have behavior problems with being mouthy. She stated the behavior referral form had never been completed for Resident #1's behaviors. Interview with the MDS coordinator, on 07/05/12	F 279		

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LOUISVILLE, KY 40205

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F 279	Continued From page 10 at 3:16 PM, revealed no one had ever reported any behavior, or use of foul language by Resident #1. Review of the Behavioral Referral and Symptom Incident Record revealed the form was not filled out until 6/30/12 after the verbal altercation with staff. Interview with the Director of Nursing (DON), on 07/05/12 at 2:03 PM, revealed the resident can become upset, but was able to redirect the behavior. In addition, the staff had informed her multiple times that the resident got angry because he/she could not go out overnight. Additionally, all staff are trained to follow the Behavior Management Program, if a resident had a behavior and a plan is not in place they should start one and the plan is then referred to behavior management team. The DON further revealed had the behavior management tool been completed and a plan started it would have made for a better experience for both the resident and housekeeper.	F 279		

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