

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

PRINTED: 12/11/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/27/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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F 000	INITIAL COMMENTS  An abbreviated survey (KY #19354) was conducted on 11/20/12 through 11/27/12 to determine the facility's compliance with Federal requirements. KY #19354 was substantiated with regulatory violations cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
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	F 225	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  F-225  1.LPN #2 received a disciplinary action for failure to report an allegation of abuse per facility policy and received one on one education with the DNS regarding the facility policy on reporting abuse.  CNA #2 was terminated, CNA #3 received a written education from the SDC regarding the policy on reporting abuse.  2.All residents have the potential to be affected by this practice. A questionnaire has been developed and distributed to staff to identify any potential problems. All residents with a BIMS score of 8 to 15 have been interviewed to identify any potential concerns with resident behavior that could contribute to abuse.	1/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcella Hodges TITLE: Executive Director (X6) DATE: 12/21/12

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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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to report an allegation of abuse for one resident (#2), in the selected sample of five residents. An allegation of inappropriate touching, involving Resident #1 and Resident #2, was reported to the charge nurse, Licensed Practical Nurse (LPN) #2 on an undetermined date during the week of 10/15/12 to 10/19/12. LPN #2 failed to report the allegation according to the facility's policy/procedure. On 10/25/12, Resident #1 was observed touching Resident #3 inappropriately in the facility hallway.</p> <p>Findings include: A review of the facility's policy/procedure, "Abuse," dated 08/31/12, revealed abuse of residents was "strictly prohibited" and all alleged violations were to be "reported immediately to the administrator of the facility." The Abuse, Components section, item #16 stated "staff received orientation and on-going annual training" to include "How to report their knowledge related to allegations and reasonable suspicion of crime." Review of the facility's policy/procedure, "Identification of an Event that May Constitute</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>3. The contact numbers for the Administrator and the Director of Nursing have been laminated and posted at each nursing station and in all CNA books and communication books. Staff were inserviced regarding the facility policy for reporting abuse and on where to find the new postings of contract numbers for the Administrator and DNS. This inservicing was presented by the Staff Development Coordinator and/or her assistant beginning 10/26/12 and completed by 12/31/12. This information will also be given to new orientees by the Administrator, Social Services Director or Staff Development Coordinator.</p> <p>4. The Social Services staff and/or the Administrator will conduct random inquiries regarding inappropriate touching between residents weekly of at least 10 staff members. The result of these inquiries will be presented to the monthly Performance Improvement Committee meeting for a period of three months and quarterly as needed thereafter.</p>		

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F 225	<p>Continued From page 2</p> <p>Abuse," dated 07/22/10, procedure item #2, revealed the Licensed Nurse was responsible to "Immediately notify the Executive Director, Director of Nursing Services and Social Services."</p> <p>1. A record review revealed the facility admitted Resident #1 on 07/22/11 and re-admitted on 09/09/11 with diagnoses to include Diabetes Mellitus Type II, Hyperlipidemia, Anemia, Cerebral Degeneration, Paraplegia, Hypertension, Cerebral Artery Occlusion, Atherosclerosis, Peripheral Vascular Disease, and Chronic Airway Obstruction.</p> <p>A review of the Minimum Data Set (MDS), dated 06/14/12, revealed the facility identified Resident #1 to be cognitively intact with daily behaviors described as "other behavioral symptoms not directed toward others (public sexual acts) that had no impact on others and had no impact on the resident. The Care Area Assessment of the MDS, dated 06/14/12, Review of Indicators, revealed Resident #1 was "noted with some behaviors, i.e. Hx of Masturbating in public." Further record review revealed Resident #1 was care planned for "displaying inappropriate behaviors such as masturbating/smearing feces" on 06/14/12.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 01/06/10 with diagnoses to include Unspecified Intellectual Difficulties, Delusional Disorder, Diabetes Type II, Hyperlipidemia, and Other Chronic Pain.</p> <p>A review of the MDS, dated 11/09/12, revealed the facility identified Resident #2 to be cognitively</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>intact. Further record review revealed the resident had no behaviors and no evidence of being depressed. Further review revealed Resident #2 was care planned on 10/29/12 for being "at risk for psychosocial well-being related to inappropriate touching by a male resident."</p> <p>Additional review of the October and November 2012 Behavior logs revealed Resident #2 demonstrated no behaviors.</p> <p>Phone interview with Certified Nurse Aide (CNA) #3, on 11/25/12 at 1:10 PM, revealed she and LPN #2 were charting at the nurse's desk. CNA #3 stated CNA #2 walked to the desk, laughed, and said, "You might want to check out [Resident #2 and Resident #1]". CNA #3 looked at LPN #2 but neither of them took it seriously. CNA #3 stated CNA #2 turned and went back down the hallway, went past the residents, and immediately came back to the desk and reported Resident #1's hand was under Resident #2's shirt. CNA #3 and LPN #2 looked at each other again, and went to the room. CNA #3 saw nothing inappropriate and the residents were in their wheelchairs, sitting face to face in the doorway. CNA #3 asked Resident #2 what they were doing and Resident #2 replied they were "playing boyfriend and girlfriend." CNA #3 took Resident #2 to his/her room across the hall, and the residents stayed apart the remainder of the shift. CNA #3 stated Resident #2 had a history of having "crushes" on men and would give them money, soda pop, or candy.</p> <p>An interview with CNA #2, on 11/26/12 at 8:00 AM, revealed she was not assigned to Resident #1 or Resident #2 on 10/25/12. She stated she</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>was getting linens for her assigned resident who was next door to Resident #1. CNA #2 saw Resident #1 and Resident #2 seated in their wheelchairs in Resident #1's doorway and they were facing each other. CNA #2 stated Resident #2 saw her coming down the hall and was smiling at her. CNA #2 saw Resident #1's hand between the legs of Resident #2 and was massaging the groin area. CNA #2 went directly to LPN #2, and reported the observation. CNA #2 stated LPN #2 and CNA #3 went to check on the residents and returned to the desk. CNA #2 assisted her assigned resident and went back into the hallway to see Resident #1's hand under Resident #2's shirt. CNA #2 reported the observation to LPN #2, who went to check on Resident #1 and Resident #2 and was accompanied by CNA #3. CNA #2 asked LPN #2 what was going on with the residents and was informed Resident #2 reported they were "playing boyfriend/ girlfriend" and LPN #2 added "I got to call the [Director of Nursing] and [Unit Manager] to see what to do." CNA #2 revealed she was called by the DON to provide a statement related to the incident between Resident #1 and Resident #2.</p> <p>Phone interview with LPN #2, on 11/27/12 at 11:47 AM, revealed she was at the nurses' desk and was informed by CNA #3 to "check out" Resident #1 and Resident #2. LPN #2 observed the residents sitting in the doorway, laughing and giggling. LPN #2 assisted Resident #2 back to his/her room, and asked Resident #2 what was going on. The resident stated they were just talking. LPN #2 observed nothing inappropriate between Resident #1 and Resident #2. LPN #1 did not report the incident as nothing was observed.</p>	F 225		

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F 225	Continued From page 5  3. A record review revealed the facility admitted Resident #3 on 11/18/08 and re-admitted on 06/07/12 with diagnoses to include Schizophrenia, Alzheimer's, Dementia, Hypertension, and Asthma.  A review of the MDS, dated 08/28/12, revealed Resident #3 was identified by the facility to be severely cognitively impaired with no identified behaviors. Further record review revealed Resident #3 was care planned for behavior problems, such as resisting care and yelling out, related to Mental Illness and Dementia.  Review of the Behavior log, dated October and November 2012, revealed behaviors demonstrated on the day shift consisted of physical behaviors toward others and resistive to care. On the evening shift the behaviors were physical behaviors toward others, verbal behaviors, and disruptive sounds. On the night shift the behavioral focus was physical behaviors toward others and resistive to care. On all shifts the interventions worked for a short time or not at all.  Interview with CNA #1, on 11/23/12 at 6:37 PM, revealed she observed Resident #3 on 10/25/12 in the wheelchair in the hallway with the left pants leg rolled up to his/her mid-thigh and stated this was a normal behavior for the resident. CNA #1 observed Resident #1 self-propel the wheelchair to Resident #3 and put his/her hand up his/her pants leg. CNA #1 immediately separated Resident #1 and Resident #3.  Additional interview with CNA #2, on 11/26/12 at	F 225			

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F 225	Continued From page 6 8:00 AM, revealed she overheard that staff was providing one to one (1:1) supervision for Resident #1 related to inappropriately touching Resident #3.  Interview with the Director of Nursing (DON), on 11/27/12 at 1:58 PM, revealed the CNAs were expected to report all suspicious incidents to the charge nurse and the charge nurse was expected to report to the unit manager and the DON. Further, the CNA was expected to ensure the reported information was passed on by the person to whom it was reported. The DON stated a CNA who suspected the information was not passed on to the appropriate person was still responsible to make sure it was reported up the chain of command. The DON stated the same principle of reporting applied with the charge nurse reporting to the unit manager and that a lack of response from the unit manager would prompt the charge nurse to report on to the next level on the chain of command. Additionally, the DON stated the CNAs were trained to separate residents with conflicting/abusive situations during new employee orientation, annually, and with an incident in the facility. The DON stated the policy/procedure required staff to report "immediately," which meant staff was to stop activities when they were aware of a situation and report after providing for the safety of the resident.	F 225			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280			

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F 280	<p>Continued From page 7 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to revise the care plan for two residents (#1 and #2), in the selected sample of five residents. Resident #1 was care planned for "displaying inappropriate behaviors such as masturbating/smearing feces" on 06/14/12. However, the resident demonstrated inappropriate touching behaviors toward another resident on an undetermined date between 10/15/12 and 10/19/12. The care plan was not revised or updated at that time to reflect the new behavior. Resident #2 was care planned on 08/10/12 for Agitation related to Mental Retardation and Delusional Disorder and was known by family and staff to have attention</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F-280</p> <p>1.The care plan of resident #1 was reviewed and revised to include "inappropriate touching behavior toward others". The care plan of resident #2 was reviewed and revised to include "attention seeking behavior, particularly to have crushes on male residents".</p> <p>2.All residents have the potential to be affected by this practice. A questionnaire has been developed and distributed to staff to identify any potential problems. All residents with a BIMS score of 8 to 15 have been interviewed to identify any potential concerns with resident behavior that could contribute to abuse.</p>	1/8/13	

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F 280	<p>Continued From page 8</p> <p>seeking behaviors. The care plan for Resident #2 was not revised or updated to reflect the knowledge of attention seeking behavior.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Comprehensive Plan of Care," dated 08/31/12, revealed the care plan was re-evaluated and modified "as necessary to reflect changes in care, service, and treatment." The "Preparation for Care Plan Meeting" section revealed the reviewer was to "discuss patient care with primary care staff" in preparation for the Care Plan meeting. Additional review of the "Communication/ Implementation" section revealed staff was to "update the care plan during the course of care delivery to reflect new problems" as the result of a patient event.</p> <p>1. A record review revealed the facility admitted Resident #1 to the facility on 07/22/11 and re-admitted on 09/09/11 with diagnoses to include Diabetes Mellitus Type II, Hyperlipidemia, Anemia, Cerebral Degeneration, Paraplegia, Hypertension, Cerebral Artery Occlusion, Atherosclerosis, Peripheral Vascular Disease, and Chronic Airway Obstruction.</p> <p>A review of the Minimum Data Set (MDS), dated 06/14/12, revealed the facility assessed Resident #1 to be cognitively intact with behaviors occurring daily and described as "other behavioral symptoms not directed toward others (public sexual acts)" that had no impact on self or others. The Care Area Assessment of the MDS, dated 06/14/12, Review of Indicators section revealed Resident #1 was identified to have</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>An audit was completed on 12/20/12 by the care plan team to validate that all behaviors from resident charts made it into the Point, Click Care (PCC) computer system. Any concerns identified were corrected at that time.</p> <p>Behavior logs are audited a minimum of three times per week (Monday-Friday) by the Social Services team to validate that new behaviors make it from the Disruptive Behavior form to the Behavior Assessment to the care plan and to the CNA care plan. Any concerns are addressed as found.</p> <p>3. All staff were trained by the Social Services team and/or the Staff Development Coordinator on the behavior management program including identifying new behaviors and how and who to notify on of these behaviors.</p>		

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F 280	<p>Continued From page 9</p> <p>"some behaviors, i.e. Hx of Masturbating in public." Further record review revealed Resident #1 was care planned for "displaying inappropriate behaviors such as masturbating/smearing feces" on 06/14/12.</p> <p>2. A record review revealed the facility admitted Resident #2 on 01/06/10 with diagnoses to include Unspecified Intellectual Difficulties, Delusional Disorder, Diabetes Type II, Hyperlipidemia, and Other Chronic Pain.</p> <p>A review of the MDS, dated 11/09/12, revealed the facility identified Resident #2 to be cognitively intact as reflected with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of the MDS revealed the resident had no behaviors and was not depressed. Record review revealed Resident #2 was care planned for "Easily agitated related to Mental Retardation and Delusional Disorder." Additionally, the staff maintained a daily Behavior log to include "Put resident at significant risk for physical illness or injury."</p> <p>Interview with Resident #2's family member, on 11/27/12 at 12:02 PM, revealed the resident always had attention seeking behavior. The family member stated the resident would not do anything harmful or hurtful to get the attention, but Resident #2 wanted to be liked by people and would give personal belongings away. The family member stated the resident did not have the mental capacity to "lie" about situations to get attention, but walked the halls in the past looking for someone to talk to. The family member stated Resident #2 did not do that anymore related to being in the wheelchair.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4. The Social Services team will continue to audit behavior logs three times per week (Monday through Friday). Any new behaviors will be reviewed for proper notification, documentation and care planning. A report will be compiled by the Social Services team monthly using data from these audits. This report will be presented monthly for three months to the monthly Performance Improvement Committee meeting and quarterly as needed thereafter.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/27/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 280	Continued From page 10 Phone interview with Certified Nurse Aide (CNA) #3, on 11/25/12 at 1:10 PM, revealed she heard and responded to the report of inappropriate touching between Resident #1 and Resident #2 on an undetermined date between 10/15/12 and 10/19/12. CNA #3 did not report the allegation to anyone.  An interview with CNA #2, on 11/26/12 at 8:00 AM, revealed an incident of inappropriate touching between Resident #1 and Resident #2 was reported to the unit charge nurse on an undetermined date between 10/15/12 and 10/19/12.  Phone interview with LPN #2, on 11/27/12 at 11:47 AM, revealed she was informed by CNA #3 to "check out" Resident #1 and Resident #2 related to the residents' behaviors.  Interview with LPN #5, on 11/27/12 at 10:43 AM, revealed Resident #2 was known to have crushes on male residents in the past and stated Resident #2 demonstrated attention seeking behavior from males, females, and staff. LPN #5 verified there was no Care Plan for attention seeking behaviors for Resident #2.	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 11  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/ procedure, it was determined the facility failed to ensure adequate supervision was provided for one resident (#1) and adequate protection for two residents (#2 and #3), in the selected sample of five residents. The facility failed to follow their "Abuse" policy/procedure in the identification of residents most at risk for being abused related to psychosocial, interactive, and /or behavioral dysfunction. Further, the facility failed to follow their "Abuse" policy/procedure in the identification of residents with a personal history that rendered them at risk for abusing other residents. Additionally, the facility failed to follow their policy/procedures, "Identification of an Event that May Constitute Abuse" with the lack of care plan intervention updates to address the residents' event outcomes and future risks. The facility also failed to follow their policy/procedure, "Comprehensive Plan of Care" with the lack of an updated care plan to reflect a new problem. Resident #1 was assessed and care planned for inappropriate sexual behaviors on 06/14/12. On an undetermined date between 10/15/12 and 10/19/12, Resident #1 was observed inappropriately touching Resident #2, who was diagnosed with Intellectual Disabilities and Delusional Disorder. On 10/25/12, Resident #1 was observed inappropriately touching Resident #3, who was assessed to be severely cognitively impaired.  Findings include:	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  F323  1. Resident #1 was placed on one to one supervision on 10/25/12 and currently remains on one to one supervision. Resident #1 was moved to the opposite side of the facility, away from Resident #2 and #3. Residents #2 and #3 were assessed and monitored for 72 hours for signs and symptoms of psychosocial distress. No concerns were noted.  The care plan of resident #1 has been revised to include inappropriate touching of other residents. The care plan of resident #2 has been revised to include a history of crushes on men and attention seeking behaviors such as giving them money, soda pop and candy toward males, females and staff.	1/8/13

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F 323	<p>Continued From page 12</p> <p>A review of the facility's policy/procedure "Abuse," dated 08/31/12, revealed the facility's responsibility to identify residents most at risk of abuse related to psychosocial, interactive, and /or behavioral dysfunction. Further, the facility failed to follow their "Abuse" policy/procedure, dated 08/31/12, in the identification of residents with a personal history that renders them at risk for abusing other residents. Additionally, the facility failed to follow their policy/procedure, "Identification of an Event that May Constitute Abuse," dated 07/22/10, in the lack of care plan intervention updates to address the resident's event outcomes and future risks. The facility also failed to follow their policy/procedure, "Comprehensive Plan of Care," dated 08/31/12, with the lack of an updated care plan to reflect a new problem identified during the course of care delivery.</p> <p>1. A record review revealed the facility admitted Resident #1 on 07/22/11 and re-admitted on 09/09/11 with diagnoses to include Diabetes Mellitus Type II, Hyperlipidemia, Anemia, Cerebral Degeneration, Paraplegia, Hypertension, Cerebral Artery Occlusion, Atherosclerosis, Peripheral Vascular Disease, and Chronic Airway Obstruction.</p> <p>A review of the Minimum Data Set (MDS), dated 06/14/12, revealed the facility identified Resident #1 to be cognitively intact with daily behaviors described as "other behavioral symptoms not directed toward others (public sexual acts) that had no impact on others and had no impact on the resident. The Care Area Assessment of the MDS, dated 06/14/12, Review of Indicators, revealed Resident #1 was "noted with some</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>2.All residents have the potential to be affected by this practice. A questionnaire has been developed and distributed to staff to identify any potential problems. All residents with a BIMS score of 8 to 15 have been interviewed to identify any potential concerns with resident behavior that could contribute to abuse.</p> <p>When a behavior that is aggressive physically or sexually is identified, residents involved will be separated immediately. The aggressor will be placed on one to one supervision until the Interdisciplinary Team can meet to determine the course of action. The affected resident will be assessed and placed on monitoring daily for 72 hours for signs and symptoms of psychosocial distress.</p>	

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F 323	<p>Continued From page 13</p> <p>behaviors, i.e. Hx of Masturbating in public." Further record review revealed Resident #1 was care planned for "displaying inappropriate behaviors such as masturbating/smearing feces" on 06/14/12.</p> <p>2. A record review revealed the facility admitted Resident #2 on 01/06/10 with diagnoses to include Unspecified Intellectual Difficulties, Delusional Disorder, Diabetes Type II, Hyperlipidemia, and Other Chronic Pain.</p> <p>A review of the MDS, dated 11/09/12, revealed the facility identified Resident #2 to be cognitively intact as reflected with a Brief Interview for Mental Status (BIMS) score of 13. Further review of the MDS revealed no evidence of depression or behaviors. Further review revealed Resident #2 was care planned to be "Easily agitated related to Mental Retardation and Delusional Disorder." Additionally, the staff maintained a daily Behavior log to include "Put resident at significant risk for physical illness or injury."</p> <p>An interview with Certified Nurse Aide (CNA) #2, on 11/26/12 at 8:00 AM, revealed an incident of inappropriate touching between Resident #1 and Resident #2 was reported to the unit charge nurse on an undetermined date between 10/15/12 and 10/19/12. CNA #2 asked the charge nurse about the incident later in the shift. CNA #2 did not report the incident further up the chain of command due to the response provided by the charge nurse.</p> <p>Phone interview with CNA #3, on 11/25/12 at 1:10 PM, revealed she heard and responded to the report of inappropriate touching between</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>3. All staff have been inserviced regarding separating the residents when physically or sexually aggressive behavior occurs. Once the residents are safe, they are to report to the charge nurse. The charge nurse is to notify the Administrator and/or Director of Nursing regarding the event and will be directed as to what further action to take, including one to one supervision, assessment and monitoring of all residents involved.</p> <p>4. The Social Services team will audit behavior logs a minimum of three times per week (Monday through Friday). Any new behaviors will be reviewed for proper notification, documentation and care planning. A report will be compiled by the Social Services team using the data from these audits. This report will be prepared and presented monthly for three months to the monthly Performance Improvement Committee meeting and quarterly as needed thereafter.</p>		

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F 323	<p>Continued From page 14</p> <p>Resident #1 and Resident #2 on an undetermined date between 10/15/12 and 10/19/12. CNA #3 revealed she did not report the allegation to anyone. She stated Resident #2 had a history of having "crushes" on men and would give them money, soda pop, or candy.</p> <p>Phone interview with Licensed Practical Nurse (LPN) #2, on 11/27/12 at 11:47 AM, revealed she was informed by CNA #3 to "check out" Resident #1 and Resident #2 related to the residents' behaviors.</p> <p>Interview with LPN #5, on 11/27/12 at 10:43 AM, revealed Resident #2 was known to have crushes on male residents in the past and stated Resident #2 demonstrated attention seeking behavior from males, females, and staff. LPN #5 verified there was no Care Plan for attention seeking behaviors for Resident #2.</p> <p>Interview with Resident #2's family member, on 11/27/12 at 12:02 PM, revealed the resident always displayed attention seeking behavior. The family member stated the resident would not do anything harmful or hurtful to get the attention but Resident #2 wanted to be liked by people and would give away personal belongings. The family member stated the resident did not have the mental capacity to "lie" about situations to get attention, but walked the halls in the past looking for someone to talk to. The family member stated Resident #2 did not do that anymore related to limitations.</p> <p>3. A record review revealed the facility admitted Resident #3 on 11/18/08 and re-admitted on 06/07/12 with diagnoses to include</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Social Services staff, the Administrator, the DNS, the ADNS, and/or the Unit Managers will conduct random inquiries of a minimum of ten staff members from all departments including all shifts and weekends. The result of these inquiries will be presented to the Performance Improvement Committee meeting monthly for a period of three months and quarterly as needed thereafter.</p>		

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F 323	<p>Continued From page 15 Schizophrenia, Alzheimer's, Dementia, Hypertension, and Asthma.</p> <p>A review of the MDS, dated 08/28/12, revealed Resident #3 was identified by the facility to be severely cognitively impaired with no identified behaviors. Further review revealed Resident #3 was care planned for behavior problems, such as resistive to care and yelling out, related to Mental Illness and Dementia.</p> <p>Review of the Behavior log for Resident #3, dated October and November 2012, revealed behaviors demonstrated on the day shift consisted of physical behaviors toward others and resistive to care. On the evening shift the behaviors were physical behaviors toward others, verbal behaviors, and disruptive sounds. On the night shift the behavioral focus was physical behaviors toward others and resistive to care.</p> <p>Interview with CNA #1, on 11/23/12 at 6:37 PM, revealed she observed Resident #3 on 10/25/12 in the wheelchair in the hallway with the left pants leg rolled up to his/her mid-thigh and stated this was a normal behavior for the resident. CNA #1 observed Resident #1 self-propel the wheelchair to Resident #3 and put his/her hand up his/her pants leg. CNA #1 immediately separated Resident #1 and Resident #3.</p> <p>Interview with the Director of Nursing (DON), on 11/27/12 at 1:58 PM, revealed the CNAs were expected to report all suspicious incidents to the charge nurse and the charge nurse was expected to report to the unit manager and the DON. Further, the CNA was expected to ensure the reported information was passed on by the</p>	F 323			

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F 323	Continued From page 16 person to whom it was reported. The DON stated a CNA who suspected the information was not passed on to the appropriate person was still responsible to make sure it was reported up the chain of command. The DON stated the same principle of reporting applied with the charge nurse reporting to the unit manager and that a lack of response from the unit manger would prompt the charge nurse to report on to the next level on the chain of command. Additionally, the DON stated the CNAs were trained to separate residents with conflicting/abusive situations during new employee orientation, annually, and with an incident in the facility. The DON stated the policy/procedure required staff to report "immediately," which meant staff was to stop activities when they were aware of a situation and report after providing for the safety of the resident.	F 323			