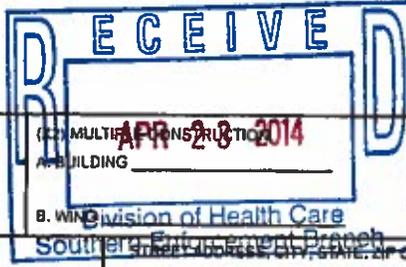


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE INSTITUTIONS BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/20/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER	21040 US HWY 421 SOUTH HYDEN, KY 41749
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Sparks TITLE: Administrator (X6) DATE: 4-9-14

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.

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2014
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH HYDEN, KY 41749		
(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 225	<p>Continued From page 1</p> <p>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 observation, interviews, record review, and a review of the facility's investigation and policy, it was determined the facility failed to ensure staff reported alleged violations of misappropriation immediately to the Administrator or Director of Nursing (DON) of the facility for one (1) of three (3) sampled residents (Resident #1). Interviews and a review of the facility's investigation revealed on 02/25/14, Resident #1 reported to Certified Medication Aide (CMA) #1 that Licensed Practical Nurse (LPN) #1 had not given the resident the correct medication the previous night (02/24/14). Continued review of the investigation revealed Resident #1 had reported the incident to LPN #2 when the incident occurred; however, LPN #2 had not reported the incident to the Administrator or DON.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Abuse Policy," revision date of December 2011, revealed all allegations involving mistreatment, neglect, or misappropriation of resident property will be reported immediately to the Director of Nursing and/or the Administrator of the facility.</p> <p>A review of the medical record revealed the facility admitted Resident #1 on 11/14/12 with diagnoses that included chronic back pain,</p>	F 225			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2014
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH HYDEN, KY 41749		
(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 225	<p>Continued From page 2</p> <p>arthritis, and depression. A review of Resident #1's physician orders, dated March 2014, revealed an order for Oxycodone 30 milligrams (mg) three times per day (TID). A review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 02/04/14, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 and was interviewable.</p> <p>Interview on 03/20/14 at 12:45 PM with Resident #1 revealed the resident thought LPN #1 had not given the resident his/her Oxycodone for a couple of days because the resident's pain was not relieved so, after discussion with his/her family member (Resident #2), the resident decided to not swallow the medication given by LPN #1 that night. Continued interview revealed on the night of 02/24/14 LPN #1 brought the resident his/her medication in a medication cup and informed the resident he/she did not have to get up, the LPN would just pour the medication in the resident's mouth; however, the resident did not swallow the medication. Further interview revealed Resident #1 took the medication (a blue pill) and showed it to LPN #2. Resident #1 revealed LPN #1 and LPN #2 then administered the resident another blue pill that looked like the Oxycodone the resident usually took.</p> <p>Interview on 03/20/14 at 12:57 PM with LPN #1 revealed on the night of 02/24/14 the LPN administered Resident #1's Oxycodone as ordered by the physician. Further interview revealed LPN #2 showed LPN #1 a blue pill Resident #1 had given to the LPN and stated Resident #1 did not feel like he/she had been given the correct medication. Continued interview revealed LPN #1 and LPN #2 wasted the blue pill and administered Resident #1 a new</p>	F 225			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2014
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH HYDEN, KY 41749		
(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 225	<p>Continued From page 3</p> <p>Oxycodone. LPN #1 revealed the Administrator should have been notified about the incident.</p> <p>Interview on 03/20/14 at 1:10 PM with LPN #2 revealed on the night of 02/24/14 Resident #1 came to the nurses' station and showed LPN #2 a blue pill and stated LPN #1 had not given the resident the correct medication, that this was not his/her pain medication. The interview further revealed LPN #2 talked with LPN #1 in the medication room and told LPN #1 what Resident #1 said and showed LPN #1 the blue pill. LPN #1 stated she had given Resident #1 the correct pain medication. Continued interview revealed LPN #2 was trying to make Resident #1 happy so LPN #1 and LPN #2 wasted the blue pill and administered Resident #1 another Oxycodone. The interview revealed the LPN should have reported the incident to the DON or Administrator immediately and notified Resident #1's physician before administering another pill; however, she was just trying to make the resident happy.</p> <p>Interview on 03/20/14 at 11:28 AM with CMA #1 revealed on 02/25/14 Resident #1 reported to her that LPN #1 had given the resident the wrong medication the night before. The interview further revealed Resident #1 did not feel like LPN #1 had given the resident his/her Oxycodone the past couple of nights because he/she was still having pain so the resident decided to not swallow the medication and show it to a nurse. Continued interview revealed the CMA immediately reported the incident to the Administrator and an investigation was started immediately.</p> <p>A review of the investigation conducted by the facility, dated 02/25/14, revealed on 02/25/14 Resident #1 reported to CMA #1 that LPN #1 had</p>	F 225			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2014
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH HYDEN, KY 41749		
(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 225	Continued From page 4 not given the resident the correct medication the previous night (02/24/14). Continued review of the investigation revealed Resident #1 had reported the incident to LPN #2 when the incident occurred; however, LPN #2 had not reported the incident to the Administrator or DON. Interview on 03/20/14 at 1:39 PM with the Administrator and the DON revealed the investigation was initiated as soon as the incident was reported by CMA #1 and the state agencies were notified immediately. The interview further revealed that multiple staff members and residents were interviewed as part of the investigation. Continued interview revealed LPN #1 and LPN #2 should have reported the incident to the supervisor on call immediately. The interview revealed the facility did not substantiate abuse or neglect had occurred because the resident did get the correct medication in a timely manner; however, LPN #2 was provided education on proper administration, documentation, and disposal of narcotic medication and LPN #1 was terminated due to failure to follow policies and procedures related to narcotic administration.	F 225			

Hyden Health and Rehabilitation

Plan of Correction

Abbreviated standard Survey Conducted 3/20/2014

F 225

1. Resident #1 no longer resides at the facility, however during the time in question, the resident did receive medications as ordered. Upon notification, the Administrator and the Director of Nursing immediately began an investigation into the incident.
2. All residents of the facility would have the potential to be affected. All interviewable residents were questioned by designated members of the CQI committee regarding neglect/abuse, mistreatment or misappropriation of residents' property. There were no concerns identified.
3. All staff have been in-serviced regarding immediate notification of any alleged mistreatment, neglect/abuse or misappropriation of resident property, including facility policy and procedures on abuse by administrative nursing staff on February 28, 2014. Designated member of the CQI Committee are interviewing randomly selected interviewable residents about any allegations of mistreatment, neglect / abuse or misappropriation of resident property.
4. The CQI Committee designee will review all allegations of reported and allegations determined through interviews with residents and staff of mistreatment, abuse / neglect or misappropriation of resident property at the weekly QA meeting to ensure that all have been reported immediately to the Administrator and/or Director of Nursing . Interviews with 3 staff members and 3 residents , selected at random, will be conducted weekly for one month and then monthly for one quarter to ensure any and all allegations have been reported appropriately to the Administrator. These reviews will be discussed on an ongoing basis in QA meetings. Any identified concerns will be addressed immediately per QA committee
5. Date of Completion : April 10, 2014