

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

PRINTED: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/22/2015
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 12/15/15, as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185142	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/22/2015
Name of Facility HERITAGE MANOR HEALTH CARE CENTER	Street Address, City, State, Zip Code 401 INDIANA AVE MAYFIELD, KY 42066	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0225</u> Reg. # <u>483.13(c)(1)(ii)-(iii), (c)(2) -</u> LSC _____	Correction Completed 12/15/2015	ID Prefix <u>F0226</u> Reg. # <u>483.13(c)</u> LSC _____	Correction Completed 12/15/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>DH</u>	Date: <u>12/22/15</u>	Signature of Surveyor: <u>Deborah A. Heidis - NCH, OK</u>	Date: <u>12/22/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on:
11/18/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42068	

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F 000	INITIAL COMMENTS	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> F225 Resident #1 was transferred to an acute setting on 10/26/15 where he/she was examined and returned to the facility. Upon return, Resident #1 was placed on alert charting and the care plan was reviewed and revised by the Interdisciplinary Team, which consists of, but is not limited to, the Executive Director, Director of Nursing, Rehab Director, RN Unit Manager, RN Case Manager, RN Assessment Coordinator, Registered Dietician, Social Services Director, and Activity Director. Resident #1 agreed to consult with Mental Health services and treatment is ongoing. CNA #1 was interviewed by the RN Director of Nursing on 10/24/15, and stated that he/she was in the room when Resident #1 stated "there is someone on top of me". CNA #1 attempted to reassure Resident #1 by stating "There is no one here but me". CNA #1 indicated that the hallucination was reported to LPN#1.	12/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Director

12/22/15

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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 "Abuse-Resident Care" policy, it was determined the facility failed to report an allegation of abuse immediately to the Administrator for one (1) of four (4) sampled residents (Resident #1) Certified Nursing Assistant (CNA) #1 reported to Licensed Practical Nurse (LPN) #1 on 10/24/15 that Resident #1 had alleged someone was on top of him/her in bed, however, LPN #1 failed to make the Administrator aware of the allegation.</p> <p>The findings include:</p> <p>Review of facility policy titled "Abuse - Resident Care", dated 07/28/14, revealed 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</p> <p>Record review revealed Resident #1 was admitted to the facility on 10/01/14 with diagnoses which included Orthopedic Aftercare, Late Effects of Cerebrovascular Accident, Quadriplegia, Chronic Pain, Bipolar Disorder, Schizophrenia, Depression, Anxiety, Muscle Spasms, and</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>On 10/25/15 during the night, Resident #1 made an allegation of rape, and was immediately transferred to the ER for evaluation and treatment.</p> <p>Residents with BIMS 8 and higher were interviewed by the Social Services Director 10/26/15 and asked whether they had ever been abused in the facility or had they ever witnessed another resident being abused. All responded "No".</p> <p>Residents with BIMS under 8 were provided skin assessments by licensed staff members on 10/26/15, with no noted concerns.</p> <p>Staff education was initiated by the RN Staff Development Coordinator on 10/26/15 regarding the facility policy for reporting abuse. All staff will be educated by 12/15/15, and those who have not received the education will not be allowed to work until the education is completed. Abuse reporting guidelines are included in the new hire process, and will be provided by the SDC.</p>		

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F 225	<p>Continued From page 2</p> <p>Neurogenic Bladder Review of the annual Minimum Data Set (MDS) assessment, dated 08/25/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of (12) twelve which indicated the resident was interviewable</p> <p>Review of an Abuse Investigation revealed Resident #1 made a sexual abuse allegation on the night of 10/24/15 to CNA #1 who reported it to LPN #1, however, LPN #1 failed to report the allegation to the Administrator The following night on 10/25/15, CNA #16 reported to LPN #6 that Resident #1 reported he/she was raped on 10/24/15. LPN #6 reported the allegation to the Administrator on the early morning of 10/26/15 and an investigation was initiated.</p> <p>Interview with CNA #1, on 11/14/15 at 12:24 PM, revealed on 10/24/15 she reported to LPN #1 that Resident #1 had reported to her that someone had been on top of him/her in the bed.</p> <p>Interview with LPN #1, on 11/13/15 at 1:36 PM, revealed CNA #1 reported Resident #1 stated someone was on top of him/her in bed on 10/24/15 in the middle of the 3:00 PM-11:00 PM shift. She stated she did not report the allegation of sexual abuse to the Director of Nursing (DON) or Executive Director (ED). She said she had "dropped the ball" and in hindsight, according to policy, she should have reported it.</p> <p>Interview with LPN #6, on 11/11/15 at 11:21 PM, revealed she had received a report of sexual abuse of Resident #1 from CNA #16 during the early morning of 10/26/15, but the incident was supposed to have happened the day before. LPN</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>In addition, Adult Protective Services has provided a Power Point presentation regarding Abuse, Misappropriation, and neglect on 12/09/15. Staff members who do not attend the presentation will be provided a copy of the presentation by the RN SDC.</p> <p>Random interviews (to identify potential concerns of abuse) of one resident from each of the four (4) halls will be conducted 3 times weekly for one month by the Executive Director and /or Director of Nursing Services. Then the interviews will be conducted 2 times weekly by the ED and/or DNS for one month, and then one time weekly for one month.</p> <p>The Quality Assurance Performance Committee which consists of, but is not limited to, Executive Director, Director of Nursing, Social Services Director, Activity Director, RN Case Manager, Medical Director, Dietary Department and Rehab Services will review the education and the results. Any concerns will be addressed with education and or counseling. The reviews will continue monthly and as needed.</p>		

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F 225	Continued From page 3 #6 stated she informed the DON and ED of the allegation. Interview with Registered Nurse (RN) #1, on 11/13/15 at 12 17 PM, revealed on 10/25/15, CNA #1 reported to her that on 10/24/15, Resident #1 alleged sexual abuse and the allegation was reported to LPN #1 on the previous night. RN #1 stated she was not aware of the allegation and LPN #1 should have started an investigation according to facility policy and the allegation should have been reported to her Supervisor and DON immediately. RN #1 further stated she reported the allegation to the DON Interviews on 11/16/15 with LPN #2 at 8 27 AM and with LPN #3 at 8 33 AM, revealed if they were told of an allegation of sexual abuse of a resident by a CNA, they would report it to their supervisor Interview with the Director of Nursing (DON), on 11/17/15 at 12 10 PM, revealed allegations of abuse should be reported immediately if suspected, reported, or seen, and the process is to notify administration (DON and Executive Director) The DON stated staff need to investigate and verify the situation.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226			

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F 226	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of the facility "Abuse-Resident Care" policy, it was determined the facility failed to implement the facility's Abuse policy related to reporting allegations of abuse immediately to the Administrator for one (1) of four (4) sampled residents (Resident #1). Certified Nursing Assistant (CNA) #1 reported to Licensed Practical Nurse (LPN) #1 on 10/24/15 that Resident #1 had alleged someone was on top of him/her in bed; however, LPN #1 failed to notify the Administrator immediately per facility policy.</p> <p>The findings include</p> <p>Review of facility policy titled "Abuse - Resident Care", dated 07/28/14, revealed 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.</p> <p>Record review revealed Resident #1 was admitted to the facility on 10/01/14 with diagnoses which included Orthopedic Aftercare, Late Effects of Cerebrovascular Accident, Quadriplegia, Chronic Pain, Bipolar Disorder, Schizophrenia, Depression, Anxiety, Muscle Spasms, and Neurogenic Bladder.</p> <p>Review of an Abuse Investigation revealed Resident #1 made a sexual abuse allegation on the night of 10/24/15 to CNA #1 who reported it to LPN #1, however, LPN #1 failed to follow the facility's policy and failed to report the allegation to the Administrator immediately. The following night on 10/25/15, CNA #16 reported to LPN #6</p>	F 226	<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>F226</p> <p>Resident #1 was transferred to an acute setting on 10/26/15 where he/she was examined and returned to the facility. Upon return, Resident #1 was placed on alert charting and the care plan was reviewed and revised by the Interdisciplinary Team, which consists of, but is not limited to, the Executive Director, Director of Nursing, Rehab Director, RN Unit Manager, RN Case Manager, RN Assessment Coordinator, Registered Dietician, Social Services Director, and Activity Director. Resident #1 agreed to consult with Mental Health services and treatment is ongoing.</p> <p>CNA #1 was interviewed by the RN Director of Nursing on 10/24/15, and stated that he/she was in the room when Resident #1 stated "there is someone on top of me". CNA #1 attempted to reassure Resident #1 by stating "There is no one here but me". CNA #1 indicated that the hallucination was reported to LPN #1.</p>	12/15/15	

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F 226	<p>Continued From page 5</p> <p>that Resident #1 reported he/she was raped. LPN #6 reported the allegation to the Administrator on the early morning of 10/26/15 and an investigation was initiated.</p> <p>Interview with CNA #1, on 11/14/15 at 12:24 PM, revealed on 10/24/15 she reported to LPN #1 that Resident #1 had reported to her that someone had been on top of him/her in the bed.</p> <p>Interview with LPN #1, on 11/13/15 at 1:36 PM, revealed CNA #1 reported Resident #1 stated someone was on top of him/her in bed on 10/24/15 in the middle of the 3:00 PM-11:00 PM shift. She stated she did not report the allegation of sexual abuse to the Director of Nursing (DON) or Executive Director (ED) per the facility's policy. She stated she had "dropped the ball".</p> <p>Interview with CNA #9, on 11/12/15 at 3:52 PM, and interviews on 11/13/15 with CNA #13 at 10:48 AM and CNA #14 at 11:28 AM revealed an allegation of abuse should be reported to Supervisor immediately.</p> <p>Interviews on 11/16/15 with LPN #2 at 8:27 AM and LPN #3 at 8:33 AM, revealed if they were told of an allegation of sexual abuse of a resident by a CNA, they would report it to the Administrator immediately.</p> <p>Interview with the on 11/17/15 at 9:14 AM with Staff Development Coordinator (SDC) revealed that all staff were educated on the facility's Abuse Policy and are told to report allegations of abuse, and suspicions immediately. She stated the CNAs report allegations to the nurse and the nurse then reports the allegation to the DON or ED.</p>	F 226	<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>On 10/25/15 during the night, Resident #1 made an allegation of rape, and was immediately transferred to the ER for evaluation and treatment.</p> <p>Residents with BIMS 8 and higher were interviewed by the Social Services Director 10/26/15 and asked whether they had ever been abused in the facility or had they ever witnessed another resident being abused. All responded "No".</p> <p>Residents with BIMS under 8 were provided skin assessments by licensed staff members on 10/26/15, with no noted concerns.</p> <p>Staff education was initiated by the RN Staff Development Coordinator on 10/26/15 regarding the facility policy for reporting abuse. All staff will be educated by 12/15/15, and those who have not received the education will not be allowed to work until the education is completed. Abuse reporting guidelines are included in the new hire process, and will be provided by the SDC.</p>		

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F 226	Continued From page 6 Interview with the Director of Nursing (DON), on 11/17/15 at 12:10 PM, revealed it is the facility's policy for allegations of abuse to be reported immediately if suspected, reported, or seen, and the process is to notify administration (DON and Executive Director).	F 226	<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>In addition, Adult Protective Services has provided a Power Point presentation regarding Abuse, Misappropriation, and neglect on 12/09/15. Staff members who do not attend the presentation will be provided a copy of the presentation by the RN SDC.</p> <p>Random interviews (to identify potential concerns of abuse) of one resident from each of the four (4) halls will be conducted 3 times weekly for one month by the Executive Director and /or Director of Nursing Services. Then the interviews will be conducted 2 times weekly by the ED and/or DNS for one month, and then one time weekly for one month.</p> <p>The Quality Assurance Performance Committee which consists of, but is not limited to, Executive Director, Director of Nursing, Social Services Director, Activity Director, RN Case Manager, Medical Director, Dietary Department and Rehab Services will review the education and the results. Any concerns will be addressed with education and or counseling. The reviews will continue monthly and as needed.</p>	