

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

PRINTED: 11/21/13  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185225</b>	(x2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(x3) DATE SURVEY COMPLETED  <b>C</b> <b>11/07/13</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROSEDALE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4250 GLENN AVENUE COVINGTON, KY 41015</b>	
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F 000	INITIAL COMMENTS  An Abbreviated Survey investigating KY#0002094 was initiated on 11/07/13 and concluded on 11/07/13. KY#0002094 was unsubstantiated with related deficiencies cited.	F 000	PLAN OF CORRECTION:  The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.	
F 226	483.13(c) DEVELOP/IMPLEMENT 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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to implement their Abuse Policy and Procedures regarding prompt reporting and investigation of suspected abuse for one (1) of three (3) sampled residents (Resident #1). A Unit Manager failed to promptly report and investigate an allegation of abuse when she was notified by a Speech Therapist that Resident #1 had reported someone had hurt him/her. The Unit Manager failed to immediately report the suspected abuse, and did not report the allegation for an hour and a half.  The findings include:  Review of the facility's policy titled, "Abuse, Neglect & Misappropriation, Reporting of" revised date of 06/16/06, revealed it was the responsibility of facility employees to promptly report any incident or suspected incident of	F 226	483.12(c) DEVELOP / IMPLEMENT ABUSE/NEGLECT, ETC POLICIES  Rosedale Manor is committed to developing and implementing written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  With regards to Resident #1 and the suspected abuse reported to the Unit Manager on 10/30/13, upon determining the delay in reporting the allegation to the DON, the Unit Manager was immediately counseled by the DON regarding our policy and the requirement that any and all allegations must immediately be reported. There should be no determination made by any staff member that the allegation does not warrant immediate notification of the DON and / or Administrator and investigation. Upon notification of the incident to administration, an immediate investigation into the allegation was initiated for resident #1.  The facility identified that the lack of following the policy, would have the potential to affect other residents under the care of this Unit Manager. In an effort to identify other residents having the potential to be affected, twelve (12) residents out of the twenty seven (27) on this neighborhood were interviewed on 10/30/13 and 11/6/13 by Social Services to determine if they had received or reported care that was rough, made them uncomfortable; if anyone had hurt them; and if they were comfortable reporting anything that makes them feel uncomfortable	12/13/13

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

TITLE

(X6) DATE

*[Signature]*

*Administrator*

*12/5/13*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable after 90 days following the date of the 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 226	<p>Continued From page 1</p> <p>resident abuse to facility management. Further review of the policy revealed the Administrator and Director of Nursing (DON) or designee was to be immediately notified of suspected abuse or incidents of abuse.</p> <p>Review of the facility's policy titled, "Investigating Abuse, Neglect &amp; Misappropriation", revised date of 06/16/06, revealed all allegations and reports of resident abuse should be promptly investigated.</p> <p>1. Review of Resident #1's medical record revealed the facility readmitted the resident on 10/02/13, with diagnoses which included Viral Encephalopathy (a Brain Disease), Diabetes, Aphasia (disturbance of the comprehension and formulation of language) and Anxiety. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/28/13 revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of seven (7) indicating cognitive impairment.</p> <p>Review of the facility Incident Form dated 11/01/13, revealed on 10/30/13 Resident #1 stated to staff a male "had thrown" him/her around. Continued review of the Incident Form revealed Resident #1 stated the man might have had "inappropriate contact" with him/her; however, was unable to state what type of contact had been made.</p> <p>Interview with Speech Therapist (ST) #1, on 11/07/13 at 1:46 PM, revealed when working with Resident #1, on 10/30/13 at breakfast, the resident appeared nervous and withdrawn; so, she asked the resident what was wrong. The ST stated Resident #1 reported a male, who worked</p>	F 226	<p>to their nurse, nurse manager, or social services and if they had been responded to timely. Each resident expressed satisfaction with their care, denied any concerns with care or staff interaction, and verbalized comfort in reporting concerns should they arise.</p> <p>The policy and procedure on Abuse, Neglect, &amp; Misappropriation was reviewed by the DON and Administrator on 11/7/13. It was determined after review that the policy and procedure is appropriate, but that it was not followed according to our expectation.</p> <p>To ensure that the deficient practice doesn't recur, all staff will be inserviced as of 12/12/13 on the Abuse, Neglect &amp; Misappropriation policy and procedure. An emphasis is being placed on the requirement that notification be made immediately and that no staff member should delay reporting because they interpret the situation to not be serious. All allegations must be immediately reported and investigated. Inservicing will be completed by the Department Directors and Supervisors for each ancillary department. Inservicing of the nursing staff will be completed by the Nurse Managers, MDS/RAI Nurses, Supervisors, and ADON's.</p> <p>To ensure that our solutions are sustained, going forward, indefinitely, all abuse allegations will be reviewed monthly by at least two (2) members of the Quality Assurance / Performance Improvement committee after each allegation, to ensure that our policy has been followed. (Members of the QAPI team that may be involved in reviewing the abuse allegations include the Administrator, Assistant Administrator, DON, ADON, Social Services, Medical Director, Nurse Manger, or MDS/RAI nurse).</p>	

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<b>F 226</b>	<p>Continued From page 2</p> <p>at the facility, had come into his/her room, had hurt him/her and did something he was not supposed to. According to the ST, Resident #t was unable to provide specifics which was not unusual due to the resident's Asphasia condition. She stated after Resident #1 reported this information to her, she went and told Unit Manager #t. The ST stated Unit Manager #1 told her she would take care of the matter.</p> <p>Interview with Unit Manger (UM) #t, on 11/07/13 at 3:1t PM, revealed she was on her way to a care conference at about 10:00 AM on 10/30/13, when the ST told her Resident #1 was feeling scared because a man had thrown him/her around. The Unit Manager stated, when the ST mentioned the resident was scared by a male, she assumed the resident was just scared by the male alde who had taken care of the resident that night. She indicated she went on to the care conference, which lasted approximately an hour and a half, before talking to the resident regarding the suspected abuse. The UM further stated, after she interviewed Resident #t she told the Director of Nursing (DON) about the allegation. Additionally, the UM revealed she did not really hear the seriousness of the situation when it was initially reported by the ST, if she had she would have acted immediately. She further stated when any type of abuse was suspected staff were supposed to immediately notify the DON.</p> <p>Interview with the Director of Social Services, on 11/07/13 at 5:45 PM, revealed when abuse was reported to a staff person they were to make sure the resident was safe and immediately report the suspected abuse to their supervisor. The Director of Social Services stated it was not appropriate that Unit Manager #1 waited an hour</p>	<b>F 226</b>	<p>Rosedale Manor has QA/PI meetings monthly. Audits concerning abuse, etc, will be reviewed monthly at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>Compliance with abuse policies will be reviewed and analyzed monthly at each QA/PI meeting and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p> <p>Rosedale Manor continues to place the safety and well-being of our residents as our highest priority.</p>		

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F 226	Continued From page 3 and a half before reporting the allegation and ensuring an investigation had been initiated per facility policy. The Director of Social Services indicated any allegation of abuse should be checked out immediately.  Interview with the Administrator, on 11/07/13 at 8:12 PM, revealed she was unaware Unit Manager #1 had not reported the suspected abuse immediately when alerted by the ST. The Administrator stated the Unit Manager did not follow the facility's policy/protocol for reporting and investigating any allegation of abuse immediately.	F 226			