

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

PRINTED: 06/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 AMENDED An Abbreviated/Partial Extended Survey investigating complaints #KY22409 and KY22437 was conducted on 11/06/14-11/20/14. Complaints KY22409 and KY22437 were unsubstantiated with unrelated deficiencies cited at a Scope and Severity of a "J". Licensed Practical Nurse (LPN) #1 was alleged to have abused Resident #5 on 11/04/14 by placing a hot pepper in Resident #5's mouth causing burning to the resident's mouth. The resident began to cry and yell "hot". The alleged abuse was witnessed by three (3) staff, Kentucky Medication Assistant (KMA) #1, Certified Nurse Aide (CNA) #2 and CNA #3; however, the staff failed to report this allegation to the Administrator. Although LPN #1 told LPN #2 what she had done on 11/05/14, LPN #2 did not report this abusive behavior until 11/07/14 (Friday after business hours) when she left a phone message on the Director of Nursing's (DON) voicemail which was not retrieved until 11/10/14 (Monday). LPN #1 continued to work with residents from 11/04/14 to 11/10/14 until the Administrator was made aware of the allegation. The LPN was terminated at that time. In addition, CNA #1 heard Registered Nurse (RN) #4 tell Resident #1 he/she was "fat" and staff was tired of getting him/her up in the sling lift. RN #4 told the resident if he/she would take his/her medication and stop being so mean to the staff, he/she would not be in the shape "(he/she) was in". RN #4 also told the resident he/she was not getting a pain pill because his/her finger nails	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rolin Chappell</i>		TITLE Administrator		(X6) DATE 6/19/15	



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 000	Continued From page 1 were dirty and needed cleaning. CNA #1 reported the alleged abuse immediately to the former Administrator; however, there was no documented evidence the former Administrator suspended the alleged perpetrator, investigated the incident and reported the incident to the appropriate State agencies, as per the facility's policy titled "Regarding Abuse", dated 09/03/08. Immediate Jeopardy (IJ) was identified in the areas of 483.13 Resident Behavior and Facility Practice at F223, F225, and F226; 483.20 Resident Assessment at F282; and, 483.75 Administration at F490 at a Scope and Severity of a "J". Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practice. Immediate Jeopardy was identified on 11/13/14 and was determined to exist on 10/18/14. The facility was notified of the Immediate Jeopardy on 11/13/14. An acceptable Allegation of Compliance (AoC) was received on 11/19/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/20/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.	F 000	As part of the allegation of compliance measures, the immediate corrective actions for Resident # 1 and Resident # 5 were to terminate LPN #1 and RN # 4. In addition to the implementation of the allegation of compliance listed to the left, the facility will implement the following plan of correction. Residents Impacted: A complete care plan review was performed by the Interdisciplinary Team (IDT) on Residents #1 and #5. Physical condition, nutritional status and risks, safety risks, and psychosocial domains were evaluated by the IDT. The IDT consists of licensed nurses including at least one Registered Nurse (RN), the Activities Director (AD), the Social Services Director (SSD), and the Dietary Manager (DM). Residents #1 and #5 continue to be monitored by licensed staff for post-traumatic signs such as changes in behavior or mood. PHQ 9 assessments are being completed and reviewed by the SSD weekly x 4, then every other week x 2, then monthly x 2, then quarterly and with any significant change in the residents' condition. No signs of post-traumatic distress such as changes in mood or behavior have been identified. Other residents potentially impacted: weekly skin assessments continue to be conducted by licensed nurses on all residents for physical signs of abuse. None have been identified.	12/24/14	
F 223 SS=J	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.	F 223			

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F 223	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to have an effective system in place to ensure two (2) of nine (9) sampled residents (Resident #1 and #5) were free from abuse by staff. Licensed Practical Nurse (LPN) #2 alleged LPN #1 physically and mentally abused Resident #5 on 11/04/14 by placing a hot pepper in Resident #5's mouth causing the resident's mouth to burn and the resident to cry out and repeatedly yell "hot". LPN #1 laughed at the resident and told staff repeatedly that it "was priceless". Kentucky Medication Assistant (KMA) #1, Certified Nurse Aide (CNA) #2 and CNA #3 all witnessed the alleged abuse but did not report it to the Administrator. LPN #1 told LPN #2 what she had done on 11/05/14; however, LPN #2 did not report it until 11/07/14 (Friday after hours) when she left a phone message on the Director of Nursing's (DON) voicemail which was not retrieved until 11/10/14 (Monday). On 10/18/14, CNA #1 witnessed Registered Nurse (RN) #4 tell Resident #1 that he/she was fat and staff was tired of getting him/her up with the sling lift. RN #4 told the resident if he/she would take his/her medication and stop being so mean to the staff, he/she would not be in the shape he/she "was in". RN #4 also told the resident she was not going to give the resident his/her pain pill because his/her finger nails were dirty and needed cleaning. CNA #1 immediately reported this alleged abuse to the former	F 223	Cognitively alert residents are being interviewed a minimum of weekly for four weeks, by the SSD, to identify potential allegations of abuse/neglect. All residents are monitored for other potential indicators of abuse such as changes in behavior or mood by the licensed nurses every shift and by the leadership team during rounds as indicated below. Any indicators are reported during the morning huddle. All resulting allegations of abuse will be reported immediately to the Administrator per facility protocol. Systemic Changes: A leadership team has been developed, members include the Administrator, Director of Nursing, Business Office Manager, Social Services Director, Activities Director, Housekeeping Supervisor, Dietary Manager, Administrative Assistant, Maintenance Supervisor, Therapy representative, Infection Control Registered Nurse, and MDS Coordinator Registered Nurse. A leadership morning huddle meeting has been established every weekday morning and an abbreviated huddle on weekends and holidays in which all allegations of abuse, skin assessments and grievances are discussed with follow-up action initiated and/or resolutions addressed and/or issues closed. All employees were required to view the Hand-in-Hand Video Series Module 4: "Being with a Person with Dementia: Actions and Reactions" by 12/17/14. Verification of employee understanding is performed by an external consulting company that interviews employees for appropriate abuse allegation and situational responses. All six Modules of the Hand in Hand training will be incorporated into the annual training and		

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F 223	<p>Continued From page 3</p> <p>Administrator; however, according to the current Administrator, there was no evidence the former Administrator investigated the allegation and reported the alleged abuse to the appropriate State agencies.</p> <p>The facility's failure to ensure residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 11/13/14 and determined to exist on 10/18/14. The facility was notified of the Immediate Jeopardy on 11/13/14. An acceptable Allegation of Compliance (AoC) was received on 11/19/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/20/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Policy Regarding Abuse", last updated 10/28/13, revealed the staff will protect the rights of patients to be free from verbal, sexual, mental abuse, corporal punishment, involuntary seclusion and misappropriations of property. Residents must not be subjected to abuse by anyone including but not limited to facility staff, other residents, consultants, volunteers, other agency staff, family members, legal guardian, friends or other individuals. Review of the facility's policy titled, "Abuse Prevention", dated 09/23/08, revealed the facility will protect and promote the rights of individual patients to be free of abuse.</p>		<p>orientation requirements for all employees.</p> <p>F 223 Annual training will be presented by the Administrator, Administrative Assistant, Director of Nursing, and/or Assistant Director of Nursing. Assurance of employee attendance and makeup sessions will be the responsibility of the employee's Department Manager. The orientation sessions will be presented by the new employee's Department Manager and/or the Orientation Coordinator. All employees were educated by the Administrator, Director of Nursing and the Owner on 11/10/14 to immediately report allegations of abuse or misconduct to the Administrator when physically present in the facility. In cases when the Administrator is not present, the employee is to immediately report the allegation or misconduct to their supervisor or charge nurse. The supervisor or charge nurse is to immediately report to the Administrator by telephone and not on a voice mail. If the Administrator does not answer or return the call within 30 minutes, the supervisor or charge nurse is to report to the Director of Nursing. If the DON doesn't answer within 30 minutes, the Owner is to be notified. Any and all employees are encouraged to call the Administrator directly at any time. The contact numbers for the Administrator, Director of Nursing and the Owner were given to all employees and is included with all new hires during orientation. In addition, the telephone company has been contacted and the Director of Nursing (DON) and Administrator now have the capability of checking voice mail messages remotely on a daily basis as increased assurance that no messages will be</p>		

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F 223	Continued From page 4 Review of the facility's policy titled, "Policy Regarding Abuse", dated 10/28/13, revealed "If a staff member is suspected of abuse then appropriate action will be taken to protect the residents during the investigation. During the course of the investigation, the staff person accused of abuse will be suspended without pay. The allegation will be reported in accordance with state and federal regulations." 1. Record review revealed the facility admitted Resident #5 on 10/08/11, with diagnoses which included Alzheimer's, Psychosis, Anxiety and Senile Dementia with behavioral disturbance. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/08/14, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of ninety-nine (99) which indicated the resident was not interviewable. Review of the Physician's Orders, dated 07/31/13, revealed an order for a pureed diet. Review of the facility's 11/04/14 video/audio surveillance recording, on 11/14/14 at 10:00 AM, revealed LPN #1 sitting at the Nurses' Station when Resident #5 came up in a wheelchair. LPN #1 removed an item from a bag and placed it in Resident #5's mouth. Resident #5 began to scream and yell "hot". Further review of the video recording revealed LPN #1 laughed at the resident for several minutes and repeatedly stated "that was priceless". Further observation revealed KMA #1, who witnessed this incident, handed Resident #5 a cup of water and asked the resident to take a drink. In addition, CNA #2 and CNA #3 were sitting at the Nurses' Station and witnessed this incident; however, they did not intervene or report the incident.	F 223	left for more than one day without being retrieved. In addition to the licensed nurses monitoring residents as part of their care on each shift, the SSD and other members of the leadership team conduct daily rounds, at least three times a day Monday through Friday between the hours of 8 am and 5 pm, on all residents to identify potential allegations of abuse as evidenced by verbal expression, changes in behavior and/or changes in mood. The facility has established a weekend/holiday leadership program with leadership rotation established and weekend/holiday leadership protocols implemented. The protocols require the designated weekend/holiday leader to be present in the facility at least four hours a day, make at least one facility round, observe at least one meal, complete the huddle requirements in addition to other tasks related to resident care and the monitoring of services provided. For a minimum of one year, the District Ombudsman will be providing sensitivity and abuse training to the employees every six months on an alternating basis with QSource, the Quality Improvement Organization (QIO) for our facility. Alternating the Ombudsman and QIO for training will ensure abuse and/or sensitivity training is provided to the care team from an outside source every three months. Monitoring: An external consulting company has been retained for a minimum of 90 days. The consulting company representatives include two Registered Nurses and one Licensed Long-Term Care		

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F 223 Continued From page 5

Interview with KMA #1, on 11/13/14 at 10:20 AM, revealed she observed LPN #1 place a hot pepper in Resident #5's mouth on the afternoon shift on 11/04/14. She stated the resident began to cry and yell "hot". KMA #1 stated she gave the resident a glass of water to help reduce the burning. Further interview with KMA #1 revealed Resident #5 was on a pureed diet. She stated the resident could have choked on the pepper. KMA #1 stated she did not report this incident because at the time she did not view the occurrence as abusive behavior toward the resident.

Interview with CNA #3, on 11/13/14 at 10:36 AM, revealed that on 11/04/14, she observed LPN #1 give Resident #5 a hot pepper from a plastic bag. CNA #3 stated the resident had reached for the bag several times during the shift and she had told the resident he/she could not have one of the peppers. CNA #3 stated LPN #1 pulled the pepper from the bag, said "here" to the resident and placed the pepper in the resident's mouth. CNA #3 stated Resident #5 was on a pureed diet and should have never been given a hot pepper because he/she could have choked on it. She stated she did not report the incident because LPN #1 was her supervisor and she was in fear of retaliation. However, the facility's policy states, "Residents must not be subjected to abuse by anyone including but not limited to facility staff, ..." and "if a staff member is suspected of abuse then appropriate action will be taken to protect the residents during the investigation."

Interview with CNA #2, on 11/13/14 at 2:40 PM, revealed she had witnessed LPN #1 give a hot pepper to Resident #5. CNA #2 stated while

F 223 Administrator. In addition, the external consulting company representatives will be completing the following (a minimum of monthly): Auditing the abuse log for compliance to AOC and POC, auditing a selection of weekly skin assessments for any signs of abuse, interviewing a selection of residents and staff for their knowledge and understanding of abuse reporting, and providing additional education on abuse policies as indicated from the above findings. The above actions and findings will be provided to the Administrator for follow-up in the monthly Quality Assurance (QA) meeting. The QA committee that meets monthly is comprised of the following members: Administrator, Director of Nursing, Dietary Manager, Business Office Manager, Administrative Assistant, Social Services Director, Activities Director, MDS Coordinator, Infection Prevention Coordinator, Housekeeping Supervisor, and the Maintenance Supervisor. Quarterly QA meetings also include the Medical Director and the Pharmacist.

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F 223	<p>Continued From page 6</p> <p>sitting at the Nurses' Station, LPN #1 tore a piece of a hot pepper off and gave it to Resident #5. CNA #2 stated the resident "flipped out" and, LPN #1 laughed at the resident's reaction and facial expressions. She stated she did not report the incident to the Administrator and gave no reason why she didn't report the incident.</p> <p>Phone interviews were attempted on 11/15/14 with LPN #2 at 9:00 AM and LPN #1 at 9:10 AM without success.</p> <p>Interview with the current Administrator, on 11/10/14 at 4:12 PM, revealed the DON retrieved a voicemail from her office phone from LPN #2 on the afternoon of 11/10/14, that was left on 11/07/14 after office hours. Further interview revealed the recording stated that LPN #1 had told her she had placed a hot pepper in Resident # 5's mouth on the evening of 11/04/14. The Administrator stated LPN #2 stated she thought about reporting the incident several times that week because she considered it to be abusive but got busy and forgot to do so. The incident was reported via telephone message after hours on 11/07/14 (Friday) and was not retrieved until the afternoon of 11/10/14 (Monday). The Administrator stated she confronted LPN #1 on 11/10/14 when the LPN arrived to work and the LPN "confessed" to placing the pepper in Resident #5's mouth but stated she was playing with the resident. The Administrator stated she terminated LPN #1 immediately as she considered this conduct to be resident abuse. Interview with the current Administrator, on 11/13/14 at 3:08 PM, revealed she expected staff to report any form of abuse immediately.</p> <p>2. Record review revealed the facility admitted</p>	F 223	

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F 223	Continued From page 7 Resident #1 on 06/14/13 with diagnoses which included Chronic Kidney Disease, Obesity, Diabetes, Congestive Heart Failure and Hypertension. Review of the Quarterly MDS Assessment, dated 10/24/14, revealed the facility assessed Resident #1's Brief Interview of Mental Status (BIMS) score as fourteen (14) indicating the resident was interviewable. During the initial tour, on 11/06/14 at 12:50 AM, Resident #1 was observed crying. During an interview with the resident, he/she stated that he/she had been verbally abused by RN #4 about two (2) weeks prior. He/she stated RN #4 told him/her that he/she was fat and staff was tired of getting him/her up with the sling lift. Resident #1 continued to cry and stated RN #4 told him/her if he/she would take his/her medication right and stop being so mean to the staff, he/she would not be in the shape he/she was in. Additionally, Resident #1 stated RN #4 also told him/her that he/she was not getting a pain pill because his/her finger nails were dirty and needed cleaning. Resident #1 stated at the time he/she wanted to kill him/herself over what RN #4 had said because of how bad it had made him/her feel. The resident stated he/she could not help that he/she required assistance. The resident stated CNA #1 had overheard the incident and had tried to console him/her. Interview with CNA #1, on 11/04/14 at 5:08 PM, revealed she had witnessed RN #4 being "verbally abusive" toward Resident #1 on 10/18/14. CNA #1 stated RN #4 told the resident "that's the reason you are sick and that's what's wrong with you now" and he/she "needed to stop being so mean". CNA #1 stated Resident #1 was crying and the resident stated "he/she did not like	F 223			

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F 223	Continued From page 8 RN #4 because she was so abusive." CNA #1 stated she immediately reported the incident to the former Administrator. CNA #1 stated that later, the former Administrator told her she had taken care of the problem that she had reported. A phone interview was attempted with RN #4, the alleged perpetrator, on 11/15/14 at 9:22 AM and again at 9:35 AM ; however, it was unsuccessful. Interview with the DON, on 11/07/14 at 10:20 AM, revealed she was aware something had happened on 10/18/14; however, the former Administrator refused to tell her what had happened. The DON stated she was never made aware of an allegation of abuse or any form of an investigation. She stated that on 10/28/14, the former Administrator fired RN #4 and she asked the former Administrator why she had fired the RN; but the former Administrator told her that she did not have to give the employee a reason. The DON stated she expected any form of abuse to be reported to her and an investigation was to be completed immediately. Upon request of documented evidence of an investigation, the facility did not present any evidence that the allegation had been investigated, RN #4 had been suspended, per facility policy, and/or the alleged abuse had been reported to the appropriate state agency. RN #4 was allowed to continue to work until the time of termination of 10/28/14 according to the former Administrator's interview. Interview with the former Administrator, on 11/06/14 at 11:15 AM, revealed while she was the Administrator of the facility, CNA #1 had reported RN #4 had verbally abused Resident #1 and she did not think anything had been done about it.	F 223			

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F 223	Continued From page 9 The former Administrator failed to report, investigate and suspend the alleged perpetrator and she did not provide a reason why this was not done. Interview with the current Administrator, on 11/10/14 at 4:12 PM, revealed she was not employed at the facility at the time of the allegation on 10/18/14. Interview with the Medical Director, on 11/13/14 at 11:04 AM, revealed he had not been made aware of the allegations made on 10/18/14 or 11/04/14 until a Quality Assurance meeting on 11/12/14. He stated the incident on 11/04/14 was a serious concern and he felt this was an obvious case of physical/mental abuse toward the resident. Additionally, he stated the incident on 10/18/14 was very unprofessional and he was very concerned because this was an obvious case of verbal/mental abuse toward this resident. He stated he had seen Resident #1 on 11/11/14 and he/she was of sound mind and felt his/her complaint was legitimate. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. The two (2) alleged perpetrators (LPN #1 and RN #4) were suspended immediately and after completion of the facility's investigation the two alleged perpetrators were terminated. 2. On 11/12/14, the Abuse Log was reviewed by the DON and Administrator. All residents with allegation of abuse in the past thirty (30) days had their abuse investigation file re-assessed for completeness of the following: Immediate reporting of allegation to Administrator, physician	F 223			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 223	<p>Continued From page 10</p> <p>and family/responsible party; immediate resident assessment; twenty-four (24) hour notification of allegation to appropriate state agency, when indicated; documentation of investigation including but not limited to; resident statement, witness (staff and family) statements, assessment of precipitating events, risks and conclusion; and five (5) day follow-up provided to State Agency, when indicated. On 11/14/14, any gaps identified from above were followed-up on by the Administrator to ensure care plans and kardexes were updated. No issues were identified.</p> <p>3. On 11/13/14, all personnel files were audited by the Business Office Manager for completion of current license, abuse registry check, and criminal background verifications. Staff with incomplete personnel files will not be allowed to work until their files are brought current. No problems were identified.</p> <p>4. On 11/07/14-11/11/14, the Social Service Director and/or RNs, interviewed all cognitively intact residents (BIMS score greater than eight {8}) for any history of potential allegations of abuse. Any allegations of abuse were logged, investigations were completed and appropriate notifications were made. No problems were identified.</p> <p>5. On 11/07/14-11/11/14 Licensed Nurse Staff conducted body audits of all non-cognitive residents (BIMS less than nine {9}) to identify any bruises, skin tears, etc, for potential abuse. Any indications of abuse were logged, investigations were completed and appropriate notifications were made. No concerns identified.</p>	F 223		

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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F 223 Continued From page 11

F 223

- 6. On 11/10/14-11/14/14, all staff was provided in-service education by the DON and the Ombudsman on abuse prohibition and reporting policies. The education will be provided annually thereafter and as indicated by the DON, Ombudsman, and/or Administrator. All staff will complete this education prior to being allowed to continue to work.
- 7. All new hires will be provided in-service education on abuse prohibition and reporting policies during their general facility orientation by the Orientation Coordinator and/or Department Supervisor.
- 8. All new hires will have their personnel records reviewed by the Business Office Manager and/or Administrator for completeness of verification and background checks, prior to their first day of work.
- 9. On 11/14/14, the Social Services Director provided the Resident Council members education on abuse prohibition and reporting to the resident council. This education will be provided quarterly thereafter.
- 10. The Administrator and/or DON will be responsible for ensuring completeness of the resident abuse files and maintaining the Abuse Log.
- 11. On 11/12/14, abuse prohibition and reporting information was posted in common areas within the facility.
- 12. The Administrator and/or DON will be responsible for verifying, during the morning meetings, that any new allegations of abuse were

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 223	Continued From page 12 reported immediately. The findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up on areas identified every month for three (3) months. 13. The Administrator and/or DON will review the abuse files weekly for timeliness in reporting, thorough investigations and appropriate resolution weekly for four (4) weeks, every other week for one (1) month, then monthly for three (3) months. The findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up on areas identified every month for three (3) months. **The State Survey Agency validated on 11/19/14 the corrective action taken by the facility as follows: 1. Interview with the current Administrator, on 11/20/14 at 10:30 AM, revealed LPN #1 and RN #4 were terminated on 11/10/14 as soon as she was made aware. 2. Review of the Abuse Log, dated 11/12/14, revealed all residents with allegations of abuse in the past thirty (30) days had their abuse investigation file reassessed for completeness. No concerns were identified. 3. Review of the Business Office Manager's log, dated 11/13/14, revealed all staff's personnel records were reviewed to ensure the abuse registry check, criminal background checks, and current license verifications were conducted. No concerns identified. 4. Review of interviews conducted on 11/07/14-11/11/14 with residents with a BIMS of	F 223			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 223	<p>Continued From page 13</p> <p>nine (9) or greater revealed no new problems identified.</p> <p>Interview with Resident #1 on 11/20/14 at 9:45 AM, revealed he/she had no additional concerns and the staff had been very nice to him/her.</p> <p>5. Review of thirty-six (36) body audits for residents with a BIMS score of eight (8) or less revealed there were no new concerns identified.</p> <p>6. Review of inservice record, dated 11/14/14, revealed all staff was inserviced on abuse prohibition and reporting policies.</p> <p>Interviews on 11/20/14 with day shift CNA #7 at 9:15 AM, day shift Restorative Aide at 9:22 AM, day shift Housekeeping Aide at 9:26 AM, day shift Certified Occupational Therapy Assistant (COTA) at 9:40 AM, Housekeeping Supervisor (all shifts) at 9:46 AM, 2nd shift LPN #4 at 10:32 AM, evening shift CNA #4 at 10:48 AM, 2nd shift CNA #5 at 10:48 AM, 3rd shift CNA #6 at 10:55 AM, day shift Business Office Manager at 12:59 PM, Maintenance Director (all shifts) at 2:00 PM, Dietary Manager (all shifts) at 2:12 PM, day shift Administrative Assistant at 2:16 PM, revealed they had received an in-service on 11/14/14 related to abuse and reporting.</p> <p>7. Review of new hire orientation training for a new hire (CNA) revealed she was educated on abuse prohibition and reporting policies.</p> <p>8. Review of three (3) Personnel Record, revealed new (CNA) background checks and abuse registry checks were completed.</p> <p>9. Review of the SSD's education, dated</p>	F 223		

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
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F 223	<p>Continued From page 14</p> <p>11/14/14, revealed Resident Council members were educated on abuse prohibition and reporting to the resident council.</p> <p>10. Interview with the current Administrator, on 11/20/14 at 2:30 PM, revealed she assumed the responsibility of ensuring the resident abuse files and maintaining the abuse log. She stated the log was reviewed daily.</p> <p>11. Observation throughout the facility revealed abuse prohibition and reporting information was posted at the West Hall lobby, front entrance, therapy entrance, and break room.</p> <p>12. Interview with Administrator, on 11/20/14 at 2:30 PM, revealed she has verified during morning meetings that new allegations of abuse were reported immediately and the findings reported during the monthly Quality Assurance (QA) meeting for follow-up every month for three (3) months.</p> <p>13. Interviews with the Administrator, on 11/20/14 at 2:30 PM, revealed she or the DON will review the abuse files for timeliness in reporting, thorough investigations and appropriate resolution weekly for four (4) weeks, every other week for one (1) month, then monthly for three (3) months and the findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up every month for three (3) months.</p>	F 223	
F 225 SS=J	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have</p>	F 225	

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 225	Continued From page 15 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 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was	F 225	As part of the allegation of compliance measures, the immediate corrective actions for Resident # 1 and Resident # 5 were to terminate LPN #1 and RN # 4. In addition to the implementation of the allegation of compliance listed to the left, the facility will implement the following plan of correction. Residents Impacted: A complete care plan review was performed by the Interdisciplinary Team (IDT) on Residents #1 and #5. Physical condition, nutritional status and risks, safety risks, and psychosocial domains were evaluated by the IDT. The IDT consists of licensed nurses including at least one Registered Nurse (RN), the Activities Director (AD), the Social Services Director (SSD), and the Dietary Manager (DM). Residents #1 and #5 continue to be monitored by licensed staff for post-traumatic signs such as changes in behavior or mood. PHQ 9 assessments are being completed and reviewed by the SSD weekly x 4, then every other week x 2, then monthly x 2, then quarterly and with any significant change in the residents' condition. No signs of post-traumatic distress such as changes in mood or behavior have been identified. Other residents potentially impacted: weekly skin assessments continue to be conducted by licensed nurses on all residents for physical signs of abuse. None have been identified.	12/24/14	

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 225	<p>Continued From page 16</p> <p>determined the facility failed to have an effective system to ensure staff reported observed incidents of abuse immediately for two (2) of nine (9) sampled residents (Residents #1 and #5).</p> <p>Licensed Practical Nurse (LPN) #1 was alleged to have abused and mistreated Resident #5 on 11/04/14 by placing a hot pepper in the resident's mouth. The resident cried out "hot" repeatedly and LPN #1 laughed at the resident's reaction. Kentucky Medication Assistant (KMA) #1, Certified Nurse Aide (CNA) #2 and CNA #3 witnessed the alleged abuse but did not report it to the Administrator. LPN #1 told LPN #2 what she had done on 11/05/14; however, LPN #2 did not report it until 11/07/14 (Friday after hours) when she left a phone message on the Director of Nurse's (DON) voicemail which was not retrieved until 11/10/14 (Monday). (Refer to F223)</p> <p>Additionally, Registered Nurse (RN) #4 was alleged to have abused and mistreated Resident #1 on 10/18/14 by calling the resident fat, telling the resident he/she was mean and refusing to administer the resident's pain medication. CNA #1 observed the alleged abuse and reported the alleged abuse to the former Administrator immediately; however, there was no evidence the former Administrator suspended the alleged perpetrator and investigated and reported the alleged abuse to the appropriate State agencies, as per facility policy. (Refer to F223)</p> <p>The facility's failure to ensure staff reported and investigated alleged abuse immediately has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 11/13/14 and</p>	F 225	<p>Cognitively alert residents are being interviewed a minimum of weekly for four weeks, by the SSD, to identify potential allegations of abuse/neglect. All residents are monitored for other potential indicators of abuse such as changes in behavior or mood by the licensed nurses every shift and by the leadership team during rounds as indicated below. Any indicators are reported during the morning huddle. All resulting allegations of abuse will be reported immediately to the Administrator per facility protocol.</p> <p>Systemic Changes: A leadership team has been developed, members include the Administrator, Director of Nursing, Business Office Manager, Social Services Director, Activities Director, Housekeeping Supervisor, Dietary Manager, Administrative Assistant, Maintenance Supervisor, Therapy representative, Infection Control Registered Nurse, and MDS Coordinator Registered Nurse. A leadership morning huddle meeting has been established every weekday morning and an abbreviated huddle on weekends and holidays in which all allegations of abuse, skin assessments and grievances are discussed with follow-up action initiated and/or resolutions addressed and/or issues closed. All employees were required to view the Hand-in-Hand Video Series Module 4: "Being with a Person with Dementia: Actions and Reactions" by 12/17/14. Verification of employee understanding is performed by an external consulting company that interviews employees for appropriate abuse allegation and situational responses. All six Modules of the Hand in Hand training will be incorporated into the annual training and</p>		

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

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NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
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F 225	<p>Continued From page 17</p> <p>determined to exist on 10/18/14. The facility was notified of the Immediate Jeopardy on 11/13/14. An acceptable Allegation of Compliance (AoC) was received on 11/19/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/20/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's Policy and Procedure titled, "Abuse Prevention Employee's Responsibility", updated 08/18/99, revealed "... If abuse is suspected, than any allegation of abuse is to be reported immediately to the Administrator, Director of Nursing (DON), Charge Nurse or Immediate Supervisor. In the absence of the Administrator when the allegation occurs, he/she should be contacted immediately and the investigation should begin immediately."</p> <p>Review of the facility's policy titled, "Policy Regarding Abuse", dated 10/28/13, revealed "... If a staff member is suspected of abuse then appropriate action will be taken to protect the residents during the investigation. During the coarse of the investigation, the staff person accused of abuse will be suspended without pay. The allegation will be reported in accordance with state and federal regulations."</p> <p>Review of an addendum to the facility's policy titled, "Abuse Prevention", updated 09/24/14, revealed staff must speak to the Administrator or DON and leaving a voice mail message does not</p>	F 225	<p>orientation requirements for all employees.</p> <p>Annual training will be presented by the Administrator, Administrative Assistant, Director of Nursing, and/or Assistant Director of Nursing. Assurance of employee attendance and makeup sessions will be the responsibility of the employee's Department Manager. The orientation sessions will be presented by the new employee's Department Manager and/or the Orientation Coordinator. All employees were educated by the Administrator, Director of Nursing and the Owner on 11/10/14 to report allegations of abuse or misconduct directly to the Administrator when physically present in the facility. In cases when the Administrator is not present, the employee is to immediately report the allegation or misconduct to their supervisor or charge nurse. The supervisor or charge nurse is to immediately report to the Administrator by telephone and not on a voice mail. If the Administrator does not answer or return the call within 30 minutes, the supervisor or charge nurse is to report to the Director of Nursing. If the DON doesn't answer within 30 minutes, the Owner is to be notified. Any and all employees are encouraged to call the Administrator directly at any time. The contact numbers of the Administrator, Director of Nursing and the Owner were given to all employees and is included with all new hires during orientation. In addition, the telephone company has been contacted and the Director of Nursing (DON) and Administrator now have the capability of checking voice mail messages remotely on a daily basis as increased assurance that no messages will be left for more than one day without being retrieved.</p>	

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

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F 225	Continued From page 18 meet the definition of contacting either the Administrator or DON. Failure to follow the abuse prevention policy and procedure may result in immediate job termination. 1. Interviews with KMA #1, CNA #2, CNA #3 and the current Administrator and review of a surveillance video, dated 11/04/14, revealed LPN #1 abused Resident #5 on 11/04/14 by placing a hot pepper in the resident's mouth. When the resident repeatedly cried out "hot", LPN #1 laughed at the resident. KMA #1, CNA #2 and CNA #3, witnessed the incident but failed to report the incident to the Administrator. On 11/05/14, LPN #1 told LPN #2 what she had done to Resident #5. However, LPN #2 failed to report the allegation until 11/07/14 (Friday after hours) when she left a message on the Director of Nursing's (DON) voicemail which was not retrieved until 11/10/14 (Friday). Interview with the current Administrator, on 11/10/14 at 4:12 PM, revealed the DON received a voicemail from LPN #2 stating LPN #1 had told her she had placed a hot pepper in Resident #5's mouth on the evening of 11/04/14. The Administrator stated the incident was reported via phone message to the DON's office after business hours on 11/07/14 (Friday) and was not retrieved until the afternoon of 11/10/14 (Monday). The Administrator revealed LPN #2 stated she thought about reporting the incident several times that week but failed to do so. Further interview with the Administrator revealed she confronted LPN #1 on 11/10/14 when she arrived to work and LPN #1 admitted she had placed a pepper in the resident's mouth and laughed at him/her. The Administrator stated LPN #1 was terminated immediately on 11/10/14	F 225	In addition to the licensed nurses monitoring residents as part of their care on each shift, the SSD and other members of the leadership team conduct daily rounds, at least three times a day Monday through Friday between the hours of 8 am and 5 pm, on all residents to identify potential allegations of abuse as evidenced by verbal expression, changes in behavior and/or changes in mood. The facility has established a weekend/holiday leadership program with leadership rotation established and weekend/holiday leadership protocols implemented. The protocols require the designated weekend/holiday leader to be present in the facility at least four hours a day, make at least one facility round, observe at least one meal, complete the huddle requirements in addition to other tasks related to resident care and the monitoring of services provided. For a minimum of one year, the District Ombudsman will be providing sensitivity and abuse training to the employees every six months on an alternating basis with QSource, the Quality Improvement Organization (QIO) for our facility. Alternating the Ombudsman and QIO for training will ensure abuse and/or sensitivity training is provided to the care team from an outside source every three months. Monitoring: An external consulting company has been retained for a minimum of 90 days. The consulting company representatives include two Registered Nurses and one Licensed Long-Term Care Administrator. In addition, the external consulting company representatives will be completing the following (a minimum of monthly): Auditing the abuse log for compliance to AOC and POC, auditing a selection of weekly skin		

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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(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
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F 225 Continued From page 19
and she considered LPN #1's actions to be resident abuse. LPN worked from the day of the incident 11/04/14, until 11/10/14 when she was terminated, as staff failed to report the incident timely. Per facility policy, "... If abuse is suspected, than any allegation of abuse is to be reported immediately to the Administrator, Director of Nursing (DON), Charge Nurse..." The addendum to the policy stated "... and leaving a voice mail message does not meet the definition of contacting either the Administrator or DON."

Interview with KMA #1, on 11/13/14 at 10:20 AM, revealed she observed LPN #1 place a hot pepper in the mouth of Resident #5 on the afternoon shift of 11/04/14. KMA stated she had received training during orientation and annually on abuse. However, she stated she initially did not see this as abuse, but later felt she should have reported this to the Administrator.

Interview with CNA #3, on 11/13/14 at 10:36 AM, revealed she observed LPN #1 give Resident #5 a hot pepper from a plastic bag. She stated she did not report the incident because LPN #1 was her supervisor and she was afraid LPN #1 would retaliate.

Interview with CNA #2, on 11/13/14 at 2:40 PM, revealed she had witnessed LPN #1 give a hot pepper to Resident #5. CNA #2 stated LPN #1 placing the pepper in the resident's mouth was wrong. She revealed she was aware of how to report alleged abuse but failed to do so.

A phone interview was attempted with LPN #2 on 11/15/14 at 9:00 AM and was unsuccessful.

2. Interviews with Resident #1 and CNA #1

F 225 assessments for any signs of abuse, interviewing a selection of residents and staff for their knowledge and understanding of abuse reporting, and providing additional education on abuse policies as indicated from the above findings. The above actions and findings will be provided to the Administrator for follow-up in the monthly Quality Assurance (QA) meeting. The QA committee that meets monthly is comprised of the following members: Administrator, Director of Nursing, Dietary Manager, Business Office Manager, Administrative Assistant, Social Services Director, Activities Director, MDS Coordinator, Infection Prevention Coordinator, Housekeeping Supervisor, and the Maintenance Supervisor. Quarterly QA meetings also include the Medical Director and the Pharmacist.

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

PRINTED: 06/11/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 225	<p>Continued From page 20</p> <p>revealed RN #4 verbally abused Resident #1 on 10/18/14. CNA #1 stated she reported the alleged abuse immediately to the former Administrator. However, the former Administrator failed to suspend the allege perpetrator and investigate and report the alleged abuse to appropriate State Agencies. Per the facility's policy, "... if a staff member is suspected of abuse then appropriate action will be taken to protect the residents during the investigation. During the coarse of the investigailon, the staff person accused of abuse will be suspended without pay."</p> <p>Interview with the former Administrator, on 11/06/14 at 11:15 AM, revealed while she was the Administrator of the facility. The Administrator stated CNA #1 had reported RN #4 had verbally abused Resident #1; however, she did not think anything had been done about the allegation. She gave no reason as to why she never investigated it as the Administrator and was fired on 10/29/14.</p> <p>Interview with the Director of Nursing (DON), on 11/04/14 at 10:20 AM, revealed she was aware something had happened in 10/18/14; however, the former Administrator refused to tell her what it was and she was not aware it involved an allegation of abuse. She stated she expected that any form of abuse of a resident should have been brought to her attention and a formal investigation should have been conducted. The DON stated she asked the former Administrator why she terminated RN #4 on 10/28/14 and she was told she did not have to give a reason.</p> <p>Interview with the current Administrator, on 11/13/14 at 3:08 PM, revealed she expected any form of abuse to be verbally reported</p>	F 225		

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

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OMB NO. 0938-0391

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F 225	<p>Continued From page 21</p> <p>immediately. She stated voicemail or electronic reporting was not acceptable. The current Administrator stated her expectations were that staff should report allegations of abuse to her or her designee immediately; the alleged abuser suspended immediately; and, the Administrator should report the allegation to the State Agency.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. The two (2) alleged perpetrators (LPN #1 and RN #4) were suspended immediately and after completion of the facility's investigation the two alleged perpetrators were terminated. 2. On 11/12/14, the Abuse Log was reviewed by the DON and Administrator. All residents with allegation of abuse in the past thirty (30) days had their abuse investigation file re-assessed for completeness of the following: Immediate reporting of allegation to Administrator, physician and family/responsible party; immediate resident assessment; twenty-four (24) hour notification of allegation to appropriate state agency, when indicated; documentation of investigation including but not limited to; resident statement, witness (staff and family) statements, assessment of precipitating events, risks and conclusion; and five (5) day follow-up provided to State Agency, when indicated. On 11/14/14, any gaps identified from above were followed-up on by the Administrator to ensure care plans and kardexes were updated. No issues were identified. 3. On 11/13/14, all personnel files were audited by the Business Office Manager for completion of 	F 225		

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 22</p> <p>current license, abuse registry check, and criminal background verifications. Staff with incomplete personnel files will not be allowed to work until their files are brought current. No problems were identified.</p> <p>4. On 11/07/14-11/11/14, the Social Service Director and/or RNs, interviewed all cognitively intact residents (BIMS score greater than eight {8}) for any history of potential allegations of abuse. Any allegations of abuse were logged, investigations were completed and appropriate notifications were made. No problems were identified.</p> <p>5. On 11/07/14-11/11/14 Licensed Nurse Staff conducted body audits of all non-cognitive residents (BIMS less than nine {9}) to identify any bruises, skin tears, etc, for potential abuse. Any indications of abuse were logged, investigations were completed and appropriate notifications were made. No concerns identified.</p> <p>6. On 11/10/14-11/14/14, all staff was provided in-service education by the DON and the Ombudsman on abuse prohibition and reporting policies. The education will be provided annually thereafter and as indicated by the DON, Ombudsman, and/or Administrator. All staff will complete this education prior to being allowed to continue to work.</p> <p>7. All new hires will be provided in-service education on abuse prohibition and reporting policies during their general facility orientation by the Orientation Coordinator and/or Department Supervisor.</p> <p>8. All new hires will have their personnel records</p>	F 225		

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 23</p> <p>reviewed by the Business Office Manager and/or Administrator for completeness of verification and background checks, prior to their first day of work.</p> <p>9. On 11/14/14, the Social Services Director provided the Resident Council members education on abuse prohibition and reporting to the resident council. This education will be provided quarterly thereafter.</p> <p>10. The Administrator and/or DON will be responsible for ensuring completeness of the resident abuse files and maintaining the Abuse Log.</p> <p>11. On 11/12/14, abuse prohibition and reporting information was posted in common areas within the facility.</p> <p>12. The Administrator and/or DON will be responsible for verifying, during the morning meetings, that any new allegations of abuse were reported immediately. The findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up on areas identified every month for three (3) months.</p> <p>13. The Administrator and/or DON will review the abuse files weekly for timeliness in reporting, thorough investigations and appropriate resolution weekly for four (4) weeks, every other week for one (1) month, then monthly for three (3) months. The findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up on areas identified every month for three (3) months.</p> <p>**The State Survey Agency validated on 11/19/14</p>	F 225		

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 24</p> <p>the corrective action taken by the facility as follows:</p> <ol style="list-style-type: none"> 1. Interview with the current Administrator, on 11/20/14 at 10:30 AM, revealed LPN #1 and RN #4 were terminated on 11/10/14 as soon as she was made aware. 2. Review of the Abuse Log, dated 11/12/14, revealed all residents with allegations of abuse in the past thirty (30) days had their abuse investigation file reassessed for completeness. No concerns were identified. 3. Review of the Business Office Manager's log, dated 11/13/14, revealed all staff's personnel records were reviewed to ensure the abuse registry check, criminal background checks, and current license verifications were conducted. No concerns identified. 4. Review of interviews conducted on 11/07/14-11/11/14 with residents with a BIMS of nine (9) or greater revealed no new problems identified. <p>Interview with Resident #1 on 11/20/14 at 9:45 AM, revealed he/she had no additional concerns and the staff had been very nice to him/her.</p> <ol style="list-style-type: none"> 5. Review of thirty-six (36) body audits for residents with a BIMS score of eight (8) or less revealed there were no new concerns identified. 6. Review of inservice record, dated 11/14/14, revealed all staff was inserviced on abuse prohibition and reporting policies. <p>Interviews on 11/20/14 with day shift CNA #7 at</p>	F 225		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 25</p> <p>9:15 AM, day shift Restorative Aide at 9:22 AM, day shift Housekeeping Aide at 9:26 AM, day shift Certified Occupational Therapy Assistant (COTA) at 9:40 AM, Housekeeping Supervisor (all shifts) at 9:46 AM, 2nd shift LPN #4 at 10:32 AM, evening shift CNA #4 at 10:48 AM, 2nd shift CNA #5 at 10:48 AM, 3rd shift CNA #6 at 10:55 AM, day shift Business Office Manager at 12:59 PM, Maintenance Director (all shifts) at 2:00 PM, Dietary Manager (all shifts) at 2:12 PM, day shift Administrative Assistant at 2:16 PM, revealed they had received an in-service on 11/14/14 related to abuse and reporting.</p> <p>7. Review of new hire orientation training for a new hire (CNA) revealed she was educated on abuse prohibition and reporting policies.</p> <p>8. Review of three (3) Personnel Record, revealed new (CNA) background checks and abuse registry checks were completed.</p> <p>9. Review of the SSD's education, dated 11/14/14, revealed Resident Council members were educated on abuse prohibition and reporting to the resident council.</p> <p>10. Interview with the current Administrator, on 11/20/14 at 2:30 PM, revealed she assumed the responsibility of ensuring the resident abuse files and maintaining the abuse log. She stated the log was reviewed daily.</p> <p>11. Observation throughout the facility revealed abuse prohibition and reporting information was posted at the West Hall lobby, front entrance, therapy entrance, and break room.</p> <p>12. Interview with Administrator, on 11/20/14 at</p>	F 225		

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

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F 225 Continued From page 26
2:30 PM, revealed she has verified during morning meetings that new allegations of abuse were reported immediately and the findings reported during the monthly Quality Assurance (QA) meeting for follow-up every month for three (3) months.

13. Interviews with the Administrator, on 11/20/14 at 2:30 PM, revealed she or the DON will review the abuse files for timeliness in reporting, thorough investigations and appropriate resolution weekly for four (4) weeks, every other week for one (1) month, then monthly for three (3) months and the findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up every month for three (3) months.

F 226 483.13(c) DEVELOP/IMPLMENT
SS=J 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 the facility's policy and procedure, it was determined the facility failed to have an effective system to ensure the implementation of the facility's Abuse policy and procedures for two (2) of nine (9) sampled residents (Residents #1 and #5).

Licensed Practical Nurse (LPN) #1 was alleged to

F 225

As part of the allegation of compliance measures, the immediate corrective actions for Resident # 1 and Resident # 5 were to terminate LPN #1 and RN # 4. In addition to the implementation of the allegation of compliance listed to the left, the facility will implement the following plan of correction. Residents Impacted: A complete care plan review was performed by the Interdisciplinary Team (IDT) on Residents #1 and #5. Physical condition, nutritional status and risks, safety risks, and psychosocial domains were evaluated by the IDT. The IDT consists of licensed nurses including at least one Registered Nurse (RN), the Activities Director (AD), the Social Services Director (SSD), and the Dietary Manager (DM). Residents #1 and #5 continue to be monitored by licensed staff for post-traumatic signs such as changes in behavior or mood. PHQ 9 assessments are being completed and reviewed by the SSD weekly x 4, then every other week x 2, then monthly x 2, then quarterly and with any significant change in the residents' condition. No signs of post-traumatic distress such as changes in mood or behavior have been identified. Other residents potentially impacted: weekly skin assessments continue to be conducted by licensed nurses on all residents for physical signs of abuse. None have been identified.

12/24/14

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

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F 226	Continued From page 27 have physically and mentally abused and mistreated Resident #5. Kentucky Medication Assistant (KMA) #1, Certified Nurse Aide (CNA) #2 and CNA #3 witnessed the alleged abuse but did not report it to the Administrator per facility policy and procedure. LPN #1 told LPN #2 what she had done on 11/05/14; however, LPN #2 did not report the incident until 11/07/14 (Friday after hours) when she left a phone message on the Director of Nursing's (DON) voicemail which was not retrieved until 11/10/14 (Monday). LPN #2 failed to follow the facility's policy and report the allegation verbally to the Administrator or Director of Nursing (DON) immediately. (Refer to F223 and F225) In addition, Registered Nurse (RN) #4 was alleged to have verbally abused and mistreated Resident #1. CNA #1 observed the alleged abuse and reported it to the former Administrator immediately; however, the former Administrator failed to suspend the alleged perpetrator and investigate and report the alleged abuse to the appropriate State Agencies, per the facility's policy and procedures. (Refer to F223 and F225) The facility's failure to ensure staff followed the facility's policy and procedure for abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 11/13/14 and determined to exist on 10/18/14. The facility was notified of the Immediate Jeopardy on 11/13/14. An acceptable Allegation of Compliance (AoC) was received on 11/19/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/20/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of	F 226	Cognitively alert residents are being interviewed a minimum of weekly for four weeks, by the SSD, to identify potential allegations of abuse/neglect. All residents are monitored for other potential indicators of abuse such as changes in behavior or mood by the licensed nurses every shift and by the leadership team during rounds as indicated below. Any indicators are reported during the morning huddle. All resulting allegations of abuse will be reported immediately to the Administrator per facility protocol. Systemic Changes: A leadership team has been developed, members include the Administrator, Director of Nursing, Business Office Manager, Social Services Director, Activities Director, Housekeeping Supervisor, Dietary Manager, Administrative Assistant, Maintenance Supervisor, Therapy representative, Infection Control Registered Nurse, and MDS Coordinator Registered Nurse. A leadership morning huddle meeting has been established every weekday morning and an abbreviated huddle on weekends and holidays in which all allegations of abuse, skin assessments and grievances are discussed with follow-up action initiated and/or resolutions addressed and/or issues closed. All employees were required to view the Hand-in-Hand Video Series Module 4: "Being with a Person with Dementia: Actions and Reactions" by 12/17/14. Verification of employee understanding is performed by an external consulting company that interviews employees for appropriate abuse allegation and situational responses. All six Modules of the Hand in Hand training will be incorporated into the annual training and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 28 Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the facility's Policy and Procedure titled, "Abuse Prevention Employee's Responsibility", updated 08/18/99, revealed "... if abuse is suspected, than any allegation of abuse is to be reported immediately to the Administrator, Director of Nursing (DON), Charge Nurse or Immediate Supervisor. In the absence of the Administrator when the allegation occurs, he/she should be contacted immediately and the investigation should begin immediately." Review of the facility's policy titled, "Policy Regarding Abuse", dated 10/28/13, revealed if a staff member is suspected of abuse then appropriate action will be taken to protect the residents during the investigation. During the coarse of the investigation, the staff person accused of abuse will be suspended without pay. The allegation will be reported in accordance with state and federal regulations. Review of an addendum to the facility's policy titled, "Abuse Prevention", updated 09/24/14, revealed staff must speak to the Administrator or DON and leaving a voice mail message did not meet the definition of contacting either the Administrator or DON. Failure to follow the abuse prevention policy and procedure may result in immediate job termination. 1. Interviews with KMA #1, CNA #2, CNA #3 and the current Administrator and review of a facility surveillance video, dated 11/10/14, revealed LPN	F 226	orientation requirements for all employees. Annual training will be presented by the Administrator, Administrative Assistant, Director of Nursing, and/or Assistant Director of Nursing. Assurance of employee attendance and makeup sessions will be the responsibility of the employee's Department Manager. The orientation sessions will be presented by the new employee's Department Manager and/or the Orientation Coordinator. All employees were educated by the Administrator, Director of Nursing and the Owner on 11/10/14 to report allegations of abuse or misconduct directly to the Administrator when physically present in the facility. In cases when the Administrator is not present, the employee is to immediately report the allegation or misconduct to their supervisor or charge nurse. The supervisor or charge nurse is to immediately report to the Administrator by telephone and not on a voice mail. If the Administrator does not answer or return the call within 30 minutes, the supervisor or charge nurse is to report to the Director of Nursing. If the DON doesn't answer within 30 minutes, the Owner is to be notified. Any and all employees are encouraged to call the Administrator directly at any time. The contact numbers of the Administrator, Director of Nursing and the Owner were given to all employees and is included with all new hires during orientation. In addition, the telephone company has been contacted and the Director of Nursing (DON) and Administrator now have the capability of checking voice mail messages remotely on a daily basis as increased assurance that no messages will be left for more than one day without being retrieved. In addition to the		

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

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F 226	<p>Continued From page 29</p> <p>#1 physically and mentally abused Resident #5 on 11/04/14 by placing a hot pepper in the resident's mouth and when the resident cried out "hot" repeatedly, the LPN laughed at the resident's reaction. Kentucky Medication Aide (KMA) #1, CNA #2 and CNA #3 witnessed the incident but the staff did not follow the facility's policy and procedure for reporting abuse immediately to the Administrator, Director of Nursing (DON), Charge Nurse or Immediate Supervisor.</p> <p>Interview with KMA #1, on 11/13/14 at 10:20 AM, revealed initially she did not see the incident that she had witnessed, involving LPN #1, as abuse. She stated later she felt she should have followed the facility's policy and reported it to the Administrator but she did not follow through with reporting.</p> <p>Interview with CNA #3, on 11/13/14 at 10:36 AM, revealed she knew the facility's policy was to report alleged abuse immediately but she did not report the alleged abuse by LPN #1 because she feared retaliation by LPN #1 because LPN #1 was her supervisor.</p> <p>Interview with CNA #2, on 11/13/14 at 2:40 PM, revealed she did not report the alleged abuse by LPN #1 that she had witnessed per the facility's policy but she was aware of how to report an allegation of abuse. CNA #2 stated she did not report the abuse because LPN #1 was her supervisor and she was afraid she would loose her job.</p> <p>An unsuccessful phone interview was attempted with LPN #2 on 11/15/14 at 9:00 AM.</p>	F 226	<p>licensed nurses monitoring residents as part of their care on each shift, the SSD and other members of the leadership team conduct daily rounds, at least three times a day Monday through Friday between the hours of 8 am and 5 pm, on all residents to identify potential allegations of abuse as evidenced by verbal expression, changes in behavior and/or changes in mood. The facility has established a weekend/holiday leadership program with leadership rotation established and weekend/holiday leadership protocols implemented. The protocols require the designated weekend/holiday leader to be present in the facility at least four hours a day, make at least one facility round, observe at least one meal, complete the huddle requirements in addition to other tasks related to resident care and the monitoring of services provided. For a minimum of one year, the District Ombudsman will be providing sensitivity and abuse training to the employees every six months on an alternating basis with QSource, the Quality Improvement Organization (QIO) for our facility. Alternating the Ombudsman and QIO for training will ensure abuse and/or sensitivity training is provided to the care team from an outside source every three months.</p> <p>Monitoring: An external consulting company has been retained for a minimum of 90 days. The consulting company representatives include two Registered Nurses and one Licensed Long-Term Care Administrator. In addition, the external consulting company representatives will be completing the following (a minimum of monthly): Auditing the abuse log for compliance to AOC and POC, auditing a selection of weekly skin assessments for any signs of abuse, interviewing</p>	

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 226	<p>Continued From page 30</p> <p>Interview with the DON, on 11/07/14 at 10:20 AM, revealed she expected staff to report any allegation of alleged abuse to her per the facility's policy and not to leave a voicemail on her phone.</p> <p>Interview with the Administrator, on 11/13/14 at 3:08 PM, revealed she expected any form of abuse to have been reported immediately in person per policy.</p> <p>Interview with the Medical Director, on 11/13/14 at 11:04 AM, revealed he had not been made aware of either allegation on 10/18/14 or 11/04/14 until a Quality Assurance meeting on 11/12/14. He stated that the incidents were of serious concern. He further stated he felt the incidents were abuse and should have been reported immediately, per the facility policy.</p> <p>2. Interviews with CNA #1, the DON and the former Administrator, revealed RN #4 verbally abused Resident #1 on 10/18/14. CNA #1 witnessed the alleged abuse and immediately reported the incident to the Administrator; however, the Administrator failed to suspend the alleged perpetrator and investigate and report the allegation to the appropriate State agencies per the facility's policy and procedure. The DON stated the former Administrator refused to inform her of the allegation. The former Administrator stated she was aware the allegation had happened, but she did not do anything about it. Per the facility's policy, "... if abuse is suspected, than any allegation of abuse is to be reported immediately to the Administrator, Director of Nursing (DON), Charge Nurse or Immediate Supervisor. In the absence of the Administrator when the allegation occurs, he/she should be contacted immediately and the investigation</p>	F 226	<p>a selection of residents and staff for their knowledge and understanding of abuse reporting, and providing additional education on abuse policies as indicated from the above findings. The above actions and findings will be provided to the Administrator for follow-up in the monthly Quality Assurance (QA) meeting. The QA committee that meets monthly is comprised of the following members: Administrator, Director of Nursing, Dietary Manager, Business Office Manager, Administrative Assistant, Social Services Director, Activities Director, MDS Coordinator, Infection Prevention Coordinator, Housekeeping Supervisor, and the Maintenance Supervisor. Quarterly QA meetings also include the Medical Director and the Pharmacist.</p>	

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

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F 226	Continued From page 31 should begin immediately." Interview with the DON, on 11/07/14 at 10:20 AM, revealed she was aware there was something that had happened on 10/18/14; however, the former Administrator refused to tell her what it involved. She stated she was never aware of an allegation of abuse or any form of investigation. Interview with the current Administrator on 11/13/14 at 4:14 PM, revealed when an allegation of abuse was received the alleged perpetrator should be suspended, an investigation should be conducted and the allegation should be reported to the appropriate State Agencies, as per the facility's policy and procedures. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. The two (2) alleged perpetrators (LPN #1 and RN #4) were suspended immediately and after completion of the facility's investigation the two alleged perpetrators were terminated. 2. On 11/12/14, the Abuse Log was reviewed by the DON and Administrator. All residents with allegation of abuse in the past thirty (30) days had their abuse investigation file re-assessed for completeness of the following: Immediate reporting of allegation to Administrator, physician and family/responsible party; immediate resident assessment; twenty-four (24) hour notification of allegation to appropriate state agency, when indicated; documentation of investigation including but not limited to; resident statement, witness (staff and family) statements, assessment of precipitating events, risks and conclusion; and five (5) day follow-up provided to	F 226			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 32 State Agency, when indicated. On 11/14/14, any gaps identified from above were followed-up on by the Administrator to ensure care plans and kardexes were updated. No issues were identified. 3. On 11/13/14, all personnel files were audited by the Business Office Manager for completion of current license, abuse registry check, and criminal background verifications. Staff with incomplete personnel files will not be allowed to work until their files are brought current. No problems were identified. 4. On 11/07/14-11/11/14, the Social Service Director and/or RNs, interviewed all cognitively intact residents (BIMS score greater than eight (8)) for any history of potential allegations of abuse. Any allegations of abuse were logged, investigations were completed and appropriate notifications were made. No problems were identified. 5. On 11/07/14-11/11/14 Licensed Nurse Staff conducted body audits of all non-cognitive residents (BIMS less than nine (9)) to identify any bruises, skin tears, etc, for potential abuse. Any indications of abuse were logged, investigations were completed and appropriate notifications were made. No concerns identified. 6. On 11/10/14-11/14/14, all staff was provided in-service education by the DON and the Ombudsman on abuse prohibition and reporting policies. The education will be provided annually thereafter and as indicated by the DON, Ombudsman, and/or Administrator. All staff will complete this education prior to being allowed to continue to work.	F 226			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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F 226 Continued From page 33

F 226

7. All new hires will be provided in-service education on abuse prohibition and reporting policies during their general facility orientation by the Orientation Coordinator and/or Department Supervisor.
8. All new hires will have their personnel records reviewed by the Business Office Manager and/or Administrator for completeness of verification and background checks, prior to their first day of work.
9. On 11/14/14, the Social Services Director provided the Resident Council members education on abuse prohibition and reporting to the resident council. This education will be provided quarterly thereafter.
10. The Administrator and/or DON will be responsible for ensuring completeness of the resident abuse files and maintaining the Abuse Log.
11. On 11/12/14, abuse prohibition and reporting information was posted in common areas within the facility.
12. The Administrator and/or DON will be responsible for verifying, during the morning meetings, that any new allegations of abuse were reported immediately. The findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up on areas identified every month for three (3) months.
13. The Administrator and/or DON will review the abuse files weekly for timeliness in reporting, thorough investigations and appropriate

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 34</p> <p>resolution weekly for four (4) weeks, every other week for one (1) month, then monthly for three (3) months. The findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up on areas identified every month for three (3) months.</p> <p>**The State Survey Agency validated on 11/19/14 the corrective action taken by the facility as follows:</p> <ol style="list-style-type: none"> 1. Interview with the current Administrator, on 11/20/14 at 10:30 AM, revealed LPN #1 and RN #4 were terminated on 11/10/14 as soon as she was made aware. 2. Review of the Abuse Log, dated 11/12/14, revealed all residents with allegations of abuse in the past thirty (30) days had their abuse investigation file reassessed for completeness. No concerns were identified. 3. Review of the Business Office Manager's log, dated 11/13/14, revealed all staff's personnel records were reviewed to ensure the abuse registry check, criminal background checks, and current license verifications were conducted. No concerns identified. 4. Review of interviews conducted on 11/07/14-11/11/14 with residents with a BIMS of nine (9) or greater revealed no new problems identified. <p>Interview with Resident #1 on 11/20/14 at 9:45 AM, revealed he/she had no additional concerns and the staff had been very nice to him/her.</p> <ol style="list-style-type: none"> 5. Review of thirty-six (36) body audits for 	F 226	

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 226	Continued From page 35 residents with a BIMS score of eight (8) or less revealed there were no new concerns identified. 6. Review of inservice record, dated 11/14/14, revealed all staff was inserviced on abuse prohibition and reporting policies. Interviews on 11/20/14 with day shift CNA #7 at 9:15 AM, day shift Restorative Aide at 9:22 AM, day shift Housekeeping Aide at 9:26 AM, day shift Certified Occupational Therapy Assistant (COTA) at 9:40 AM, Housekeeping Supervisor (all shifts) at 9:46 AM, 2nd shift LPN #4 at 10:32 AM, evening shift CNA #4 at 10:48 AM, 2nd shift CNA #5 at 10:48 AM, 3rd shift CNA #6 at 10:55 AM, day shift Business Office Manager at 12:59 PM, Maintenance Director (all shifts) at 2:00 PM, Dietary Manager (all shifts) at 2:12 PM, day shift Administrative Assistant at 2:16 PM, revealed they had received an in-service on 11/14/14 related to abuse and reporting. 7. Review of new hire orientation training for a new hire (CNA) revealed she was educated on abuse prohibition and reporting policies. 8. Review of three (3) Personnel Record, revealed new (CNA) background checks and abuse registry checks were completed. 9. Review of the SSD's education, dated 11/14/14, revealed Resident Council members were educated on abuse prohibition and reporting to the resident council. 10. Interview with the current Administrator, on 11/20/14 at 2:30 PM, revealed she assumed the responsibility of ensuring the resident abuse files and maintaining the abuse log. She stated the	F 226			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
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F 226	Continued From page 36 log was reviewed daily. 11. Observation throughout the facility revealed abuse prohibition and reporting information was posted at the West Hall lobby, front entrance, therapy entrance, and break room. 12. Interview with Administrator, on 11/20/14 at 2:30 PM, revealed she has verified during morning meetings that new allegations of abuse were reported immediately and the findings reported during the monthly Quality Assurance (QA) meeting for follow-up every month for three (3) months. 13. Interviews with the Administrator, on 11/20/14 at 2:30 PM, revealed she or the DON will review the abuse files for timeliness in reporting, thorough investigations and appropriate resolution weekly for four (4) weeks, every other week for one (1) month, then monthly for three (3) months and the findings will be reported during the monthly Quality Assurance (QA) meeting for follow-up every month for three (3) months.	F 226			
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was	F 282	In addition to the implementation of the allegation of compliance, listed on the left, the facility will implement the following plan of correction. Resident impacted: Resident # 5 did not experience a choking episode as the result of eating a diet texture different than care planned. The resident was reassessed by therapy on 12/10/14 for diet texture, appropriateness and type of assistance necessary with diet intake. The resident's care plan and Kardex were updated on 12/16/14 to reflect the addition of a mechanical soft food item, preferably in the sandwich form, to the resident's diet with every meal.	12/24/14	

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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F 282	<p>Continued From page 37</p> <p>determined the facility failed to ensure services provided or arranged by the facility were provided by qualified persons in accordance with the written plan of care for one (1) of nine (9) sampled residents (Resident #5). The facility failed to ensure Resident #5's care plan interventions for a pureed diet and to supervise, cue and assist with decision making were implemented.</p> <p>Licensed Practical Nurse (LPN) #1 was alleged to have physically and mentally abused Resident #5. The resident was care planned for supervision, cueing, and assistance with decision making and a pureed diet; however, it was determined LPN #1's abusive behaviors towards the resident failed to ensure those needs were met in accordance with the care plan.</p> <p>The facility's failure to implement the care plan has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 11/13/14 and determined to exist on 10/18/14. The facility was notified of the Immediate Jeopardy on 11/13/14. An acceptable Allegation of Compliance (AoC) was received on 11/19/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/20/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Comprehensive Care Plan", not dated, revealed</p>	F 282	<p>Other residents potentially impacted: All residents, regardless of BIMS score, identified as having altered texture diets, requiring supervision, cueing and/or assistance with diet intake, had their care plans reviewed for appropriateness of current interventions by the Interdisciplinary Care Plan Team on 12/16/14. Residents identified as having altered texture diets and weight loss, have been reassessed by the Registered Dietician on 12/17/14. Residents identified above as experiencing intake difficulty with their current texture will be referred to therapy for diet screening. Additionally, residents with a BIMS score > 10 were interviewed 12/16/14 by the Social Services Director and the Activities Director to determine if their diet choices and their meal assistance needs are being provided. All results were positive with no follow-up issues identified. Systemic changes: On 12/23/14, in-service education will be provided to direct care staff by the Director of Nursing and Therapy on the following: different diet textures, types of diet assistance; supervision, cueing, set-up, feeding, etc.; approaches for promoting diet intake for residents with dementia, and providing resident opportunity in decision making during dining. The above training will be added for all new direct care staff during their orientation. Monitoring: A licensed nurse will oversee meal delivery in the dining room in order to monitor for compliance to resident care plans and kardex interventions related to diet served, diet assistance and choices.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 282	Continued From page 38 the facility was to 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. Record review revealed the facility readmitted Resident #5 on 10/08/11 with diagnoses which included Alzheimer's, Psychosis, Anxiety and Senile Dementia with behavioral disturbance. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/06/14, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of ninety-nine (99) indicating the resident was not interviewable. Review of the Physician's Orders, dated 07/31/13, revealed Resident #5 had a Physician's Order for a pureed diet. Review of the Comprehensive Care Plan, initiated 01/30/14, revealed Resident #5 was at risk for choking and was on a pureed diet. Review of a Comprehensive Care Plan, dated 03/29/14, revealed the facility had assessed the resident to have impaired cognitive and physical deficits with interventions to supervise, cue and assist with decision making. Interview with Kentucky Medication Aide (KMA) #1, on 11/13/14 at 10:20 AM, revealed she observed LPN #1 place a hot pepper (a pepper that was not pureed) in Resident #5's mouth on the afternoon shift of 11/04/14. The resident began to cry and yell "hot". KMA #1 stated the resident was cognitively impaired, unable to make decisions and depended on staff to be responsible for his/her safety at all times. KMA	F 282	Additional licensed staff will oversee meal delivery for residents who receive their meals in their room, during meal pass, for compliance to their care plans and kardex interventions related to diet served, diet assistance and choices. The DON and/or Administrator will conduct an unannounced meal audit of residents with altered diet textures for compliance to their care plans and kardexes once a week for four weeks, every other week for two weeks, and monthly for two months. Findings will be brought before the Quality Assurance committee for follow-up if indicated. Actions listed in the allegation of compliance, listed on the left, specifically related to psychosocial needs of residents, continue. The care plan and Kardex for Resident # 5 was updated by the Director of Nursing on 11/13/14 to include, "I need to be redirected when reaching for potentially unsafe items." On 11/14/14 a Registered Nurse completed a comprehensive physical assessment and care plan review on Resident #5. The care plan review included psychosocial needs with no additional changes needed as a result of the assessment. The IDT performed another comprehensive care plan review on 12/9/14 and again determined no additional changes in the plan of care were indicated. For other resident's potentially affected by this deficient practice: All new residents will have a psychosocial assessment completed by the SSD within 72 hours of admission to the facility and an initial psychosocial care plan and kardex developed as indicated. All residents with a change in their psychosocial condition will be	

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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(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
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F 282 Continued From page 39
#1 stated the resident was also on a pureed diet and was at risk for choking.

Interview with Certified Nurse Aide (CNA) #3, on 11/13/14 at 10:36 AM, revealed she observed LPN #1 give Resident #5 a hot pepper from a plastic bag. CNA #3 stated Resident #5 was on a pureed diet and should have never been given a hot pepper. CNA #3 revealed the resident could have choked on the pepper.

Interview with CNA #2, on 11/13/14 at 2:40 PM, revealed the resident was unable to make a conscious choice and staff was responsible for the resident's safety and well-being.

Interview with the Dietary Manager, on 11/12/14 at 4:31 PM, revealed Resident #5 was ordered a pureed diet. She revealed a pureed diet would be the consistency of baby food and nothing whole. She stated the resident receiving anything whole could cause choking and possible aspiration.

Interview with the Director of Nursing (DON), on 11/07/14 at 10:20 AM, revealed she expected each resident to have a Comprehensive Care Plan and the care plans should be followed at all times for each resident.

Interview with the Administrator, on 11/13/14 at 3:08 PM, revealed she expected staff to always follow the care plan for each resident.

Interview with the Medical Director, on 11/13/14 at 11:04 AM, revealed he expected each resident to have a care plan and the staff should follow them per policy.

F 282 reassessed by the DON and/or SSD within 72 hours with subsequent care plan and kardex updates as indicated. The physician will be notified of the changes in the residents' condition. Monitoring: Beginning the week of 11/17/14, the Director of Nursing, Assistant Director of Nursing, or Registered Nurse Charge Nurse has conducted direct care employee interviews for understanding of residents with psychosocial needs and appropriate implementation of the resident care plans weekly x 4 weeks, every other week x 2 weeks, then monthly x 3 months. Beginning the week of 11/17/14 the IDT has conducted reviews on the appropriateness and effectiveness of interventions for residents with psychosocial care plans weekly times four weeks, every other week times x 2, then monthly for three months. Findings from the above are presented to the monthly QA committee by the SSD or the DON.

**The facility implemented the following actions to

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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(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
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F 282 Continued From page 40
remove the Immediate Jeopardy:

1. The two (2) perpetrators (LPN #1 and Registered Nurse (RN) #4) were suspended immediately and after completion of the facility's investigation the two perpetrators were terminated.
2. On 11/14/14, Resident #5 and Resident #1 were assessed by the RN MDS Coordinators and RN Supervisor for changes in their psychosocial condition with their care plans and kardexes updated.
3. On 11/15/14 and 11/16/14, residents with mental health and/or dementia diagnoses were reassessed for changes in their psychosocial condition by RNs and/or the Social Service Director, with their care plans and kardexes updated as indicated. Thirty-nine (39) were assessed out a census of fifty-one (51).
4. On 11/14/14-11/16/14, State Registered Nurse Aides (SRNAs), KMAs LPNs and RNs were provided in-service education by the Administrator, RN Supervisor and/or Social Service Director, on the following topics: Understanding the psychosocial needs of residents; documenting and reporting changes in the psychosocial needs of residents; and, implementation of resident psychosocial care plans and Activities of Daily Living records. SRNAs, KMAs, LPNs, and RNs will not be allowed to return to work until they have completed the above training. All education has been completed
5. The above education will be provided by the Orientation Coordinator and/or Department

F 282

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
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F 282	<p>Continued From page 41</p> <p>Supervisor to SRNAs, KMAs, LPNs, and RNs new hires and/or any staff during their orientation process and prior to providing direct care.</p> <p>6. All new resident admissions will have a psychosocial assessment completed by the Social Services Director or Admission Nurse, within seventy-two (72) hours of admission to the facility and an initial psychosocial care plan and kardex developed as indicated.</p> <p>7. All residents that exhibit changes in their psychosocial condition will be reassessed by the DON and/or Social Services Director within seventy-two (72) hours. The resident's care plan and kardex will be updated and the physician will be notified of the changes.</p> <p>8. The Social Service Director, Administrator, and/or DON will interview direct care staff for understanding of residents with psychosocial needs and appropriate implementation of the resident care plans. This will be conducted on all three (3) shifts weekly times four (4) weeks, every other week times one (1) month, then monthly for three (3) months. Results of the interviews will be reviewed by the Quality Assurance (QA) committee to ensure appropriateness of interview frequency.</p> <p>9. The Interdisciplinary Team will meet and review the appropriateness and effectiveness of interventions for residents with psychosocial care plans weekly times four (4) weeks, every other week times one (1) month, then monthly for three (3) months. Findings will be brought to the QA Committee by the DON and/or Social Services Director monthly for additional follow-up of areas identified.</p>	F 282		

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 282 Continued From page 42

F 282

10. The DON and/or Administrator will review all SRNA, KMA, LPN and RN new hires' information to ensure psychosocial training has been conducted as indicated above, prior to the new hire providing direct care to residents. Findings will be brought to the QA Committee by the DON and/or Social Services Director monthly for additional follow-up of areas identified.

**The State Survey Agency validated on 11/19/14, the corrective action taken by the facility on as follows:

1. Interview with the current Administrator, on 11/20/14 at 10:30 AM, revealed LPN #1 and RN #4 were terminated on 11/10/14 as soon as she was made aware of the allegations.
2. Interview with the current Administrator, on 11/20/14 at 2:30 PM, revealed Resident #1 and #5 were assessed and care planned and kardexes updated if required. Review of the assessments, care plans and kardexes for Resident #1 and #5 revealed no concerns.
3. Review of the Psychosocial Assessments for residents with a mental health and/or dementia diagnosis, dated 11/15/14-11/16/14 revealed the residents were reassessed for changes in psychosocial conditions and care plans/kardexes were updated. Thirty-nine (39) of fifty-one (51) residents were assessed with no concerns identified.
4. Review of the Employee Sign In Sheets revealed 100% of all staff was reeducated on 11/14/14-11/16/14 related to the abuse policy, understanding the psychosocial needs of the

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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F 282 Continued From page 43

residents, documenting and reporting changes in psychosocial needs of residents, and implementation of residents' psychosocial care plans and ADL records. Posts test were completed same day as the in-service date.

Interviews on 11/20/14 with CNA #7 at 9:15 AM, a Restorative Aide at 9:22 AM, a Housekeeping Aide at 9:26 AM, a Certified Occupational Therapy Assistant (COTA) at 9:40 AM, the Housekeeping Supervisor at 9:46 AM, LPN #4 at 10:32 AM, CNA #4 at 10:48 AM, CNA #5 at 10:48 AM, CNA #6 at 10:55 AM, the Business Office Manager at 12:59 PM, the Maintenance Director at 2:00 PM, the Dietary Manager at 2:12 PM, and the Administrative Assistant at 2:16 PM, revealed they were inserviced on 11/14/14 on abuse reporting and assessing residents for change, understanding the psychosocial needs of the residents, documenting and reporting of changes in psychosocial needs and implementation of the care plans.

5. Review of new hire orientation training for a new hire (CNA) revealed psychosocial education was provided.

6. Interview with the current Administrator, on 11/20/14 at 11:15 AM, revealed the facility had not had any new admits since 11/10/14.

7. Interview with the current Administrator, on 11/20/14 at 2:30 PM, revealed all residents that exhibit changes in their psychosocial condition will be reassessed by the DON and/or Social Services Director within seventy-two (72) hours. The resident's care plan and kardex will be updated and the physician will be notified of the changes.

F 282

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
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F 282	Continued From page 44 Interview with the DON on 11/20/14 at 2:52 PM, revealed she was aware the residents were to be assessed for signs of psychosocial changes within 72 hours of the time the change was identified. 8. The Social Services Director, Administrator, and /or DON are conducting ongoing interviews with direct care staff regarding understanding of residents with psychosocial needs and appropriate implementation of residents care plans. A review of the monitoring sheet revealed interviews were conducted on 11/19/14 and 11/20/14 with direct care staff regarding their understanding of residents with psychosocial needs and appropriate implementation of residents care plans. The monitoring sheet was blocked out for future weeks for all three shifts. Interview on 11/20/14 at 2:30 PM with the current Administrator revealed she was ensuring the direct care staff was fully aware of the importance of monitoring the residents for psychosocial changes and that this should be reported to their supervisor immediately. 9. Review of Interdisciplinary Team (IDT) meeting held on 11/18/14 (usually meets on Tuesday) revealed revisions were made to the residents' care plans as needed related to monitoring of appropriateness and effectiveness of interventions for residents with psychosocial problems. 10. A review of the new hire (CNA) personnel record, revealed the Administrator educated the CNA on psychosocial training.	F 282			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1084 HOLIDAY LANE FULTON, KY 42041	
(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 490 F 490 SS-J	Continued From page 45 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Administrator's Position Description, and review of the facility's policy/procedure, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being for residents residing in the facility. On 10/18/14, Certified Nursing Assistant (CNA) #1 reported to the former Administrator that Registered Nurse (RN) #4 verbally abused and mistreated Resident #1; however, the former Administrator failed to suspend the alleged perpetrator and investigate and report the alleged abuse to the appropriate State Agencies, per the facility's policy and procedures. The facility's failure to ensure the Administrator administered the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident has caused or is likely to cause serious injury, harm, impairment or death to a resident.	F 490 F 490	In addition to the implementation of the allegation of compliance, the facility will implement the following plan of correction. The Administrator that was present during the time of findings identified was terminated. A new facility Administrator was hired on 11/06/14. An external long-term care consulting company has been retained to provide ongoing and routine education, training and support to the new administrator on a monthly basis for a minimum of 90 days. The new administrator has completed training given by the Owner on the following: job description and responsibilities, abuse policies and procedures, abuse reporting, investigating and compliance monitoring, resident rights, and care planning processes. The external consultants will provide a report to the facility owner on a monthly basis, reflecting the administrator's performance and compliance to job responsibilities.	12/24/14

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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--------------------	--	---------------	---	----------------------

F 490	<p>Continued From page 46</p> <p>Immediate Jeopardy was identified on 11/13/14 and determined to exist on 10/18/14. The facility was notified of the Immediate Jeopardy on 11/13/14. An acceptable Allegation of Compliance (AoC) was received on 11/19/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/20/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Policy Regarding Abuse", last updated 10/28/13, revealed any suspected abuse of a resident is to be reported immediately to the administrator which will conduct an investigation of the alleged abuse. "... If a staff member is suspected of abuse then appropriate action will be taken to protect the residents during the investigation. During the course of the investigation, the staff person accused of abuse will be suspended without pay. The allegation will be reported in accordance with state and federal regulations."</p> <p>Review of the facility's policy titled, "Abuse Prevention", dated 09/23/08, revealed the facility will protect and promote the rights of individual patients to be free of abuse.</p> <p>Review of the "Comprehensive Job Description" for the Administrator, revised 11/01/13, revealed the position of the Administrator is to oversee the day-to-day operations of the facility. The Administrator must know and understand the federal and state regulations and must implement</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 490	Continued From page 47 and continuously update changes as they occur. Interview with the former Administrator, on 11/06/14 at 11:15 AM, revealed while she was the Administrator of the facility, CNA #1 had reported to her that RN #4 had verbally abused Resident #1. During further interview with the Administrator, she stated she did not think anything had been done about the allegation. The former Administrator failed to report, investigate and suspend the alleged perpetrator and she did not provide a reason why this was not done. However, the facility's policy states, "... suspected abuse of a resident is to be reported immediately to the administrator who will conduct an investigation of the alleged abuse." Interview with the DON, on 11/07/14 at 10:20 AM, revealed she was aware something had happened on 10/18/14 (the day RN #4 was alleged to have abused Resident #1); however, the former Administrator refused to tell her what had happened. The DON stated she was never made aware of an allegation of abuse or any form of an investigation. Upon request of documented evidence of an investigation, the facility did not present any evidence that the allegation had been investigated, RN #4 had been suspended, per facility policy, and/or the alleged abuse had been reported to the appropriate state agency. Interview with the former Administrator revealed RN #4 was allowed to continue to work until she was terminated on 10/28/14. Interview with the facility's Owner, on 12/08/14 at 4:10 PM (post survey interview), revealed the former Administrator had been in her position for twenty-seven (27) years. He stated the former Administrator was a licensed Long Term	F 490			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 490	Continued From page 48 Administrator and he was confident that she was knowledgeable of the State and Federal regulatory requirements on investigating and reporting abuse. Further interview revealed he expected her to have followed the regulations. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 11/12/14, the Abuse Log was reviewed by the DON and the current Administrator. All residents with allegation of abuse in the past thirty (30) days had their abuse investigation file re-assessed for completeness of the following: Immediate reporting of allegation to Administrator, physician and family/responsible party; immediate resident assessment; twenty-four (24) hour notification of allegation to appropriate state agency, when indicated; documentation of investigation including but not limited to: resident statement, witness (staff and family) statements, assessment of precipitating events, risks and conclusion; and five (5) day follow-up provided to State Agency, when indicated. On 11/14/14, any gaps identified from above were followed-up on by the Administrator to ensure care plans and kardexes were updated. No issues were identified. 2. On 11/13/14, all personnel files were audited by the Business Office Manager for completion of current license, abuse registry check, and criminal background verifications. Staff with incomplete personnel files will not be allowed to work until their files are brought current. No problems were identified. 3. On 11/07/14-11/11/14, the Social Service	F 490			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
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F 490	Continued From page 49 Director and/or RNs, interviewed all cognitively intact residents (BIMS score greater than eight (8)) for any history of potential allegations of abuse. Any allegations of abuse were logged, investigations were completed and appropriate notifications were made. No problems were identified. 4. On 11/07/14-11/11/14 Licensed Nurse Staff conducted body audits of all non-cognitive residents (BIMS less than nine (9)) to identify any bruises, skin tears, etc, for potential abuse. Any indications of abuse were logged, investigations were completed and appropriate notifications were made. No concerns identified. 5. On 11/10/14-11/14/14, all staff was provided in-service education by the DON and the Ombudsman on abuse prohibition and reporting policies. The education will be provided annually thereafter and as indicated by the DON, Ombudsman, and/or Administrator. All staff will complete this education prior to being allowed to continue to work. 6. All new hires will be provided in-service education on abuse prohibition and reporting policies during their general facility orientation by the Orientation Coordinator and/or Department Supervisor. 7. All new hires will have their personnel records reviewed by the Business Office Manager and/or Administrator for completeness of verification and background checks, prior to their first day of work. 8. On 11/14/14, the Social Services Director provided the Resident Council members	F 490			

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 490	Continued From page 50 education on abuse prohibition and reporting to the resident council. This education will be provided quarterly thereafter. 9. The facility Owner and the Ombudsman educated the current Administrator on the actions that should be taken when there is an allegation of abuse/neglect. The Administrator or designated staff will do the following: A. If the resident identifies the perpetrator, he/she will suspend the perpetrator immediately and he/she will be removed from the facility pending the investigation. B. The resident (if interviewable) will provide a statement of the allegation. C. If the allegation is physical in nature, he/she will ensure a skin assessment of the resident(s) has been conducted to identify any signs of physical or psychosocial injury. D. The resident(s) family/ responsible party and physician is to be notified immediately. E. Within twenty-four (24) hours, he/she will notify the appropriate authorities (Office of Inspector General, Adult Protective Services/Centralized Intake, Ombudsman and Law Enforcement (if required.)). F. He/She will review any precipitating events or risks that have have contributed to the allegation which will be reported to the Leadership Team during morning meeting. G. A conclusion will be reached within five (5) days and appropriate action will be taken based on the findings of the investigation which will be reported to the Office of Inspector General, Adult Protective Services, Ombudsman and resident(s) physician. H. All evidence of the above actions will be documented in the abuse log and the	F 490			

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

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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(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
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F 490	<p>Continued From page 51</p> <p>administrator will review the abuse log for appropriate completion and follow up as required.</p> <p>**The State Survey Agency validated on 12/08/14, the corrective action taken by the facility on as follows:</p> <ol style="list-style-type: none"> 1. Review of the Abuse Log, dated 11/12/14, revealed all residents with allegations of abuse in the past thirty (30) days had their abuse investigation file reassessed for completeness. No concerns were identified. 2. Review of the Business Office Manager's log, dated 11/13/14, revealed all staff's personnel records were reviewed to ensure the abuse registry check, criminal background checks, and current license verifications were conducted. No concerns identified. 3. Review of interviews conducted on 11/07/14-11/11/14 with residents with a BIMS of nine (9) or greater revealed no new problems identified. <p>Interview with Resident #1 on 11/20/14 at 9:45 AM, revealed he/she had no additional concerns and the staff had been very nice to him/her.</p> <ol style="list-style-type: none"> 4. Review of thirty-six (36) body audits for residents with a BIMS score of eight (8) or less revealed there were no new concerns identified. 5. Review of inservice record, dated 11/14/14, revealed all staff was inserviced on abuse prohibition and reporting policies. <p>Interviews on 11/20/14 with day shift CNA #7 at</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
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F 490	Continued From page 52 9:15 AM, day shift Restorative Aide at 9:22 AM, day shift Housekeeping Aide at 9:26 AM, day shift Certified Occupational Therapy Assistant (COTA) at 9:40 AM, Housekeeping Supervisor (all shifts) at 9:46 AM, 2nd shift LPN #4 at 10:32 AM, evening shift CNA #4 at 10:48 AM, 2nd shift CNA #5 at 10:48 AM, 3rd shift CNA #6 at 10:55 AM, day shift Business Office Manager at 12:59 PM, Maintenance Director (all shifts) at 2:00 PM, Dietary Manager (all shifts) at 2:12 PM, day shift Administrative Assistant at 2:16 PM, revealed they had received an in-service on 11/14/14 related to abuse and reporting. 6. Review of new hire orientation training for a new hire (CNA) revealed she was educated on abuse prohibition and reporting policies. 7. Review of three (3) Personnel Record, revealed new (CNA) background checks and abuse registry checks were completed. 8. Review of the SSD's education, dated 11/14/14, revealed Resident Council members were educated on abuse prohibition and reporting to the resident council. 9. A Post Survey interview with the current Administrator, on 12/08/14 at 3:38 PM, revealed on 11/06/14 she assumed the position of facility Administrator. She stated she was trained by the facility owner on 11/06/14 and by the Ombudsman on 10/14/14 related to abuse prohibition and the facility's policies on report abuse. She revealed if there was an allegation of abuse, she or her designee would: identify the alleged perpetrator and suspend immediately and remove from the facility pending the investigation. She stated the resident (if	F 490			

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F 490	Continued From page 53 interviewable) would provide a statement of the allegation. She revealed if the allegation is physical in nature, she would ensure a skin assessment of the resident(s) has been conducted to identify any signs of physical or psychosocial injury and the resident(s) family/responsible party and physician would be notified immediately. She stated within twenty-four (24) hours, she would notify the appropriate authorities (Office of Inspector General, Adult Protective Services/Centralized Intake, Ombudsman and Law Enforcement (if required.)) She would review and assess any precipitating events or risks that may have contributed to the allegation and report to the Leadership Team during morning meeting. A conclusion will be reached within five (5) days and appropriate action taken based on the findings of the investigation which would be reported to the Office of Inspector General, Adult Protective Services, Ombudsman and resident(s) physician. She stated all evidence of the above actions will be documented in the abuse log and she would review the abuse log for appropriate completion and follow up as required.	F 490			