

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

PRINTED: 10/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/05/2012
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NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353
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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#00019149 and KY#00019143 was conducted 10/04/12 through 10/05/12. KY#00019149 was substantiated with a deficiency cited at F-226 at a scope and severity of a "D". KY#00019143 was substantiated with no deficiencies cited.

F 226 483.13(e) DEVELOP/IMPLMENT SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

F 000 The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.

F 226 This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to implement their written policies and procedures that prohibit abuse of residents. The facility failed to ensure all alleged violations involving abuse were reported immediately to the Administrator of the facility. In addition, the facility failed to have an effective system to ensure residents were protected after an allegation of abuse for one (1) of four (4) sampled residents (Resident #1).

Facility staff failed to immediately report an allegation of abuse involving Resident #1 to the Administrator; therefore, the delay in notification of the alleged abuse prevented the facility from protecting the residents from further potential abuse.

F 226 The facility has a policy and procedure in place that prohibits mistreatment, neglect, abuse of residents however that policy was not followed by two nursing assistants therefore causing a delay in reporting. The alleged incident occurred on 9/23/12 and was not reported until 9/24/12. The alleged employee was immediately suspended on 9/24/12 when the incident was reported to the director of nursing and her employment terminated on 9/28/12 upon completion of the facility investigation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Boyley</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10-23-12</i>
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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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The findings include:

Review of the facility's "Abuse Prevention" Policy, revised 05/11, revealed in the event of alleged abuse the facility would immediately assess the resident, notify the Physician and responsible party, and protect the resident from further harm or incident. The policy also stated that the employee and/or employees implicated in the allegation would be suspended until the investigation was complete.

Review of employee files revealed that five (5) out of five (5) sampled employee files contained a form titled: "Elder Abuse" which stated staff were to immediately report any suspicious activity or inappropriate conversation in order to prevent elder abuse. Review of the document revealed it was dated and signed by each employee during orientation including State Registered Nurse Aide (SRNA) #1, the alleged perpetrator.

Review of Resident #1's medical record revealed the facility admitted the resident on 06/04/12 with diagnoses which included Dementia and a History of (Trans Ischemia Attack) TIA's. Review of Resident #1's Comprehensive Plan of Care, dated 06/09/12 revealed the resident had an alteration in cognitive status related to diagnoses of Dementia and TIA with severe cognitive impairment noted. Per the Comprehensive Plan of Care, Resident #1 was able to verbalize some needs, but staff was to anticipate other needs. Several interventions were noted, including anticipating and meeting resident needs as indicated. Review of the Annual Minimum Data Set (MDS)

Employee's # 2 and #3 re-educated on abuse policy and on reporting immediately on 10/1/12 and 10/15/12 by ADON

30 residents were interviewed by DON and QA nurse 9/24/12 through 10/16/12, no concerns identified.

30 employee interviews conducted 9/24/12 through 10/16/12, no other abuse concerns noted. Then 10 staff interviews conducted 10/21/12 by the weekend supervisor to ensure re-education is being effective, no concerns noted.

10/12/12 DNS Reviewed any allegations that haven't been reviewed by OIG since the 9/24/12 self reported allegation, one of the resident to resident altercations with no injury sustained noted to have a delay in reporting.

Staff re-education on our abuse policy and reporting requirements initiated on 9/24/12 following the reported allegation and all staff will be re-educated by 10/24/12.

Twenty staff questionnaires on reporting allegations of abuse will be

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F 226	<p>Continued From page 2</p> <p>Assessment, dated 06/14/12 revealed the facility assessed the resident as cognitively impaired with a Brief Interview of Mental Status (BIMS) score of five (05) out of fifteen (15).</p> <p>Review of the facility's investigation, dated 09/28/12, revealed SRNA #2 and SRNA #3 stated that SRNA #1 had told them on 09/23/12 not to assist Resident #1 to bed because he/she would just be on the call light again and she (SRNAs #1) didn't have time for that. However, both SRNA #2 and SRNA #3 failed to report the incident until 09/24/12.</p> <p>Further review of the facility's investigation, dated 09/28/12, revealed SRNA #2, reported on 09/24/12 that on the day before, 09/23/12, she witnessed SRNA #1 jerk the call light out of Resident #1's hand and told the resident he/she had rang the light enough and he/she needed to stop.</p> <p>Interview with Resident #1 was attempted on 10/04/12 at 3:42 PM; however, the resident was unable to answer questions appropriately.</p> <p>Interview, on 10/04/12 at 3:06 PM, with SRNA #3 revealed that on 09/23/12 she witnessed SRNA #1 telling both SRNA #2 and SRNA #3 to not put Resident #1 to bed because "she did not have time to fool with him/her". SRNA #3 stated she heard SRNA #1 say this sometime after lunch when Resident #1 was requesting to go to bed. SRNA #3 reported that in the event of an alleged abuse staff members were to report to the Charge Nurse and Director of Nursing (DON) as soon as it happened. Further interview with SRNA #3 revealed she did not report what she heard to</p>	F 226	<p>completed weekly x 4, then monthly x 3 then quarterly by the QA Nurse, ADON, the weekend and night shift supervisors, and results reviewed through our QA processes.</p> <p>10-25-12</p>

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the Charge Nurse on 09/23/12, but she did say something in passing about SRNA #1 being aggravated. However, she did not remember whom she said this to.

Interview, on 10/04/12 at 4:05 PM, with SRNA #2 revealed that on 09/23/12 she was in the room with Resident #1 when she saw SRNA #1 "jerk" the call light from Resident #1's hand and told Resident #1 in a loud voice, "Do not push the call light, that's enough. No more." SRNA #2 also reported that SRNA #1 pointed her finger in Resident #1's face while talking to him/her. SRNA #2 reported this occurred around 7:00 PM on 09/23/12. SRNA #2 stated she did not report this to the nurse on 09/23/12 because she did not want to cause conflict and that SRNA #1 was very confrontational. When SRNA #2 was questioned by the surveyor as to whom she was to report allegations of abuse and when she was to report, SRNA #2 replied that they were to be reported to the nurse on duty, weekend supervisor, and DON as soon as you see it happen. SRNA #2 reported that SRNA #1 worked the remainder of her shift on 09/23/12.

Review of the employee time clock record for SRNA #1 revealed on 09/23/12, she clocked in at 6:47 AM and clocked out at 10:47 PM.

Interview, on 10/04/12 at 4:25 PM, with SRNA #1 (alleged perpetrator) revealed she denied all allegations of abuse. SRNA #1 reported she showed Resident #1 her/his call light was working but denied she raised her voice or jerked the call light from Resident #1's hand. When asked by the surveyor if Resident #1 was wanting to go to bed before supper, she denied the resident was

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F 226	<p>Continued From page 4</p> <p>acting as if he/she wanted to go to bed. She further stated, she was aggravated and had told other SRNAs not to assist Resident #1 to bed because it was right before dinner and she wanted the resident left in the wheelchair until after dinner. SRNA #1 stated that she worked her entire shift on 09/23/12, and was not aware of any allegations of abuse against her until 09/24/12 when she was contacted by the Director of Nursing (DON) and told she was under investigation for abuse. SRNA #1 said the DON told her that she could not return to work until the investigation was complete.</p> <p>Interview, on 10/05/12 at 10:00 AM, with Licensed Practical Nurse (LPN) #1 who was assigned to Resident #1 on 09/23/12 from 3:00 PM until 11:00 PM, at the time of the alleged incidents, revealed that she was not informed of any allegations of abuse on 09/23/12. LPN #1 stated she did not recall any comments from either SRNA #2 or SNRA #3 regarding SRNA #1's behavior.</p> <p>Interview, on 10/05/12 at 11:00 AM, with LPN #2 who worked Resident #1's unit on 09/23/12 from 7:00 PM until 7:00 AM, revealed she was not informed of any allegations of abuse on 09/23/12 and did not recall any comments from either SRNA #2 or SNRA #3 regarding SRNA #1's behavior.</p> <p>Interview, on 10/05/12 at 12:05 AM, with the DON revealed she was not informed of any allegations of abuse involving Resident #1 until 09/24/12 at approximately 2:00 PM by SRNA #2 via telephone. Further interview with the DON revealed staff members were to immediately notify the nurse working the wing, the DON and</p>	F 226	

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F 226	Continued From page 5 the Administrator as soon as abuse was witness or alleged. The DON also stated, as soon as allegations were made, the alleged perpetrator should be immediately suspended pending investigation. Interview, on 10/05/12 at 12:39 PM, with the Administrator revealed the investigation of the alleged abuse on 09/23/12 of Resident #1 by SRNA #1 was not initiated until 09/24/12. The Administrator also reported the alleged perpetrator worked her entire shift on 09/23/12, because no reports of abuse were received until 09/24/12. Further interview with the Administrator revealed staff should have notified Administration of the allegation on 09/23/12, in order to protect residents from further abuse, as per facility policy.	F 226		