

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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

R E C E I V E D

DEC 22 2011

(X3) DATE SURVEY COMPLETED
C
12/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2011
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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>	F 225	<p>F225 Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure continuing compliance with State and Federal Regulations.</p> <p>1) Resident #1 did not suffer any injury or negative effects from this incident. The physician, responsible party, DCBS and OIG have been made aware of this incident.</p> <p>2) The administrator and DON interviewed other alert and oriented residents in the facility and staff members on duty during this period of time and there were no other allegations of abuse against CMA #9 or anyone else.</p> <p>3) CMA #9 has been terminated from employment at this facility. SRNA #8 and LPN's #1 and #2 have been</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Said M. Gales, Administrator 12-22-11

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 225	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of Resident Abuse Report Form and facility policy it was determined the facility failed to ensure all alleged violations involving mistreatment or abuse were reported immediately to the administrator of the facility for one of three sampled residents (Resident #1). Resident #1 was abused by Certified Medication Aide (CMA) #9 on 11/27/11; the incident was reported by Certified Nurse Aide (CNA) #8 to Licensed Practical Nurses #1 and #2. However, both LPNs failed to report the incident to the Administrator.</p> <p>The findings include:</p> <p>Review of the facility policy (not dated) revealed all allegations involving mistreatment or abuse were to be reported immediately to the Director of Nursing (DON) and/or the Administrator of the facility. Personnel on the 3:00 PM to 11:00 PM shift were to report to the House Supervisor or Charge Nurse.</p> <p>A review of the Resident Abuse Report Form dated 11/28/11, revealed on 11/27/11, at 7:20 PM, Resident #1 "was finishing up smoke break" and CNA #8 "was telling him that his time was</p>	F 225	<p>counseled by the Director of Nursing about their failure to follow company policy of abuse reporting and re-inserviced on the importance of promptly reporting any type of abuse to supervisory staff. All staff have been re-inserviced on the Abuse policy and procedures by the Director of Nursing and Administrator.</p> <p>4) The Administrator will review all allegations and investigative reports with the CQI committee during weekly meetings to ensure that all incidents have been handled appropriately and reported timely. Any irregularities will be corrected immediately.</p> <p>5) Completion Date: 12/23/11.</p>		

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F 225	<p>Continued From page 2</p> <p>almost up. She said that [CNA #9] then came into the smoke room and held [Resident #1's] arms down and told [CNA #8] to take the cigarette out of his hand. [Resident #1] was fighting against [CNA #9] but she wouldn't let [Resident #1] go, said [Resident #1] knew better than that. [CNA #8] took cigarette to keep it from burning him and [CNA #9] took him out of the smoke room."</p> <p>Interview with CNA #8 on 12/05/11, at 6:00 PM, revealed she had supervised the 7:00 PM "smoke break" on 11/27/11. She stated there were two minutes left in the break and she was coaxing Resident #1 to finish the cigarette. According to CNA #8, CNA #9 came into the room, got behind Resident #1's back, "grabbed" both of the resident's arms pinning the arms to the chest, and instructed CNA #8 to take the cigarette away. CNA #8 stated she explained to CNA #9 that the resident had two minutes left, and CNA #9 said "no," Resident #1 "has got to learn to stop doing this; take the cigarette." CNA #8 stated the discussion lasted approximately two minutes before she removed the cigarette from the resident's hand due to the possibility the cigarette would burn the resident's fingers. CNA #8 further stated CNA #9 "threw" Resident #1's hands down and told the resident "you're going to learn not to do this," and gave the resident's wheelchair a push out into the hall. CNA #8 stated that as CNA #9 was assisting the resident down the hall in the wheelchair CNA #9 stated, "Whoever has him needs to put him to bed cause he has got to learn he won't be down here for the 9:00 PM smoke break." According to CNA #8, she reported the incident immediately to Licensed Practical Nurse (LPN) #2 and was told by LPN #2</p>	F 225		
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F 225	<p>Continued From page 3</p> <p>there was nothing she could do because she had not been there to witness the incident. CNA #8 stated she was told to write a note explaining the situation and leave the note for the Clinical Coordinator to read the next day.</p> <p>Interview with LPN #2 on 12/06/11, at 9:00 AM, revealed CNA #8 reported the incident between CNA #9 and Resident #1 to her. LPN #2 stated she was not aware of what process to follow and she and CNA #8 discussed the incident with LPN #1. LPN #2 stated she told CNA #8 she would leave a report of the incident for the Clinical Coordinator to see the next day. However, LPN #2 stated she forgot to write a report of the incident to leave for the Clinical Coordinator. LPN #2 further stated she had been in-serviced on abuse by the facility and stated she should have reported the incident to the charge nurse that was "on call."</p> <p>Interview with LPN #1 on 12/05/11, at 5:30 PM, revealed LPN #2 and CNA #8 had reported the incident that occurred between Resident #1 and CNA #9 to her on 11/27/11. LPN #1 stated, to her knowledge, no one reported the incident to the charge nurse that was on call the night the incident occurred. She stated she told CNA #8 she needed to call and report the incident the next day. LPN #1 further stated CNA #9 should have been sent home the night of the incident but she "didn't think about it."</p> <p>A review of an in-service on the facility's abuse policy revealed the facility had provided an in-service training to LPN #1 and LPN #2 related to abuse/reporting abuse on 10/28/11.</p>	F 225		

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F 225	Continued From page 4 Interview with the Clinical Coordinator on 12/06/11, at 11:24 AM, revealed after CNA #8 reported the incident to LPN #2, the LPN should have called the charge nurse that was on-call and at that point the charge nurse would have informed the DON of the incident. Interview with the DON and the Administrator on 12/06/11, at 5:45 PM, revealed facility staff, including LPN #8 and LPN #9, had received in-service education related to the facility's abuse/reporting abuse policy on 10/28/11. The DON and Administrator stated the incident should have been reported to the charge nurse that was on-call at the time of the incident, CNA #9 should have been removed from direct resident care, and an investigation of the incident should have been initiated.	F 225			