

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

PRINTED: 09/28/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/15/2011 |
|---|--|--|--|---|
| NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160 | |
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| F 000 | INITIAL COMMENTS | F 000 | Facility Administrator states that the plan of correction contained here-in constitutes the facility's allegation of compliance with all deficiencies cited, that no separate notification of compliance is required by virtue of this allegation of compliance, and that this allegation of compliance may presume the facility's compliance until substantiated by a revisit or other means. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported | F 225 | F225 Resident #1 was assessed for any injuries on 09/03/11 by Weekend Nurse Supervisor. The Social Service Department interviewed Resident#1 on 09/05/11 to assess for any psychosocial issues. The Social Service Department will follow up with Resident #1 weekly for 4 weeks to ensure that she feels safe and is not fearful of any staff member. | |

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

TITLE

(X6) DATE

[Signature]

X Administrator X 10/07/11

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.

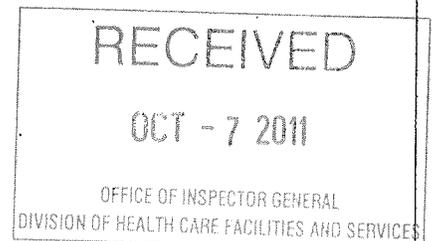
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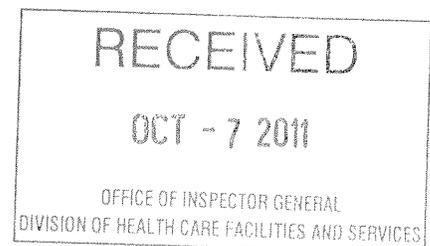
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| F 225 | <p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and 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, record review, and review of the Abuse Prohibition Policy, it was determined the facility failed to ensure alleged violations involving abuse were reported immediately to the Administrator of the facility and to other officials in accordance with State law for one (1) of three (3) sampled residents, Resident #1. A Certified Nursing Assistant, (CNA) #3, witnessed CNA #5 being verbally abusive to Resident #1 and failed to report the incident immediately to the administrative staff. The facility failed to prevent further potential of abuse while the investigation was in progress for one (1) of three (3) sampled residents, Resident #1. CNA #5 was observed on two different occasions approaching Resident #1 while an abuse investigation was in progress.</p> <p>The findings include:</p> <p>Review of the Abuse Prohibition Policy, dated 02/05/03, revealed any incident of abuse or suspected abuse must be reported immediately to the available charge staff person at the facility. Events that should be reported and will be investigated include, verbal reports/ complaints from residents/family and witnessed verbal or physically abusive incidents. I</p> | F 225 | <p>Meetings are being held beginning on 10/06/11 and continuing through 10/14/11 with facility staff to inquire about any abuse situations they may have witnessed but not reported. We will be using this opportunity to re-educate staff on the Abuse Prohibition Policy, including their responsibility to report, the procedure to report, and how to follow up on any report they may make. These meetings will be conducted by Nursing Home Administrator and Department Managers. The Social Service Department will visit with alert and oriented residents beginning on 10/07/11 and continuing through 10/14/11 to inquire about any incidents of mistreatment or feelings of fear. Director of Nursing will review all reports of injuries of unknown origin for the past 6 months to identify any injury that was suspicious, and to ensure appropriate investigation of all injuries had occurred. CNA#3 was</p> | |



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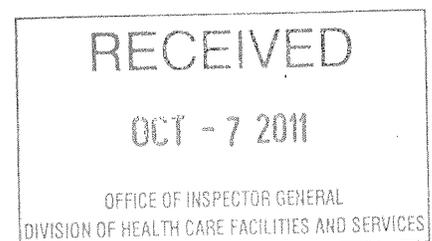
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| F 225 | Continued From page 2 Interview with the Director of Nursing (DON), on 09/15/11 at 11:50 AM, revealed staff were to report any abuse to the charge nurse immediately. Interview with the Administrator, on 09/15/11 at 12:30 PM, revealed staff members were to report verbally abusive behavior as soon as they saw it occur. Further review of the Abuse Prohibition Policy revealed any individual suspected of causing abuse was to be removed from direct patient care and reassigned non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was made by the Administrator at the facility level or the Governing Body or appointed designee at the corporate level. Further interview with the DON, on 09/15/11 at 11:50 AM, revealed staff were to intervene and protect the resident and then remove the staff member from the area immediately. Interview with CNA #3, on 09/13/11 at 3:31 PM, revealed CNA #3 witnessed CNA #5 standing outside the restroom door yelling at Resident #1 to "get out of the bathroom". CNA #3 stated she kept on walking to answer a call light and did not report immediately. Staff Abuse Interview, with CNA #3, on 09/13/11 at 3:35 PM revealed she was aware to report alleged abuse or neglect as soon as it occurs. CNA #3 further stated the incident involving CNA #5 yelling at Resident #1 was abuse. | F 225 | counseled individually on 09/16/11 by ADON and East Unit Manager regarding her failure to report. In-servicing on the Abuse Prohibition Policy will be repeated monthly for 3 months then every six months. Newly hired employees will be in-serviced during orientation. The Social Service Department will attend the Resident Council Meeting monthly for 3 months then annually to review with residents the abuse policy and solicit input on staff behaviors. The Social Service Department will review all abuse allegations weekly to determine that the policy was followed appropriately. They will report their findings to the facility QA Committee no less than quarterly for 3 quarters then as directed by the QA Committee to ensure sustained compliance. Date of completion 10-18-11 | 10/18/11 |



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| F 225 | <p>Continued From page 3</p> <p>Interview with the Director of Nursing (DON), on 09/15/11 at 11:50 AM, revealed she was not aware of any staff member witnessing CNA #5 being verbally abusive to Resident #1 before the physical abuse episode. The DON further stated the incident would not of escalated to what it became if CNA #3 would have reported the verbal abuse.</p> <p>Interview with the Licensed Practical Nurse (LPN) #1 (supervisor), on 09/13/11 at 10:41 AM, revealed she told CNA #5 to go to the supervisor's office while she talked to Resident #1. Resident #1 explained when he/she was going to the bathroom, CNA #5 slapped him/her. CNA #5 comes back to the room were LPN #1 and Resident #1 were and begins to demonstrate on Resident #1's collar what had occurred. LPN #1 stated she told CNA #5 to leave the facility and to not come back into the building. LPN #1 stated she watched as CNA #5 left the building. The LPN Supervisor then called the DON.</p> <p>Interview with LPN #2, on 09/13/11 at 3:51 PM, revealed she witnessed CNA #5 leaving the building and going to the smoking area. When the Supervisor left to call the DON, CNA #5 came back into the building. As she left the med room she approached CNA #5 because she knew CNA #5 was not suppose to be in the building. CNA #5 was standing next to Resident #1 and stated "tell them this was an accident".</p> <p>Interview with CNA #4, on 09/13/11 at 4:18 PM, revealed as she was standing at the nurses station, CNA #5 come in from the back door and approached Resident #1. CNA #5 came up to Resident #1 leaned down and said something to</p> | F 225 | | |



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| F 225 | Continued From page 4 Resident #1. CNA #4 further stated, she did not try to stop CNA #5 because she did not know what was going on at the time. Interview with the DON, on 09/13/11 at 4:57 PM, revealed she would find it alarming the resident was confronted by the staff member. The staff are to protect the residents and get the residents out of harms way. Interview with the CNA #5, on 09/14/11 at 4:01 PM, revealed she denied demonstrating the incident on Resident #1; however, she went back to apologize to Resident #1 and wanted to let Resident #1 know, it was an accident. | F 225 | | |

