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

2nd SOD

PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 08/12/2015
NAME OF PROVIDER OR SUPPLIER: HICKS GOLDEN YEARS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633	

RECEIVED SEP 21 2015 Division of Health Care Southern Enforcement Branch

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F 000	INITIAL COMMENTS	F 000		
	An abbreviated standard survey (KY23624) was conducted on 08/12/15. The complaint was substantiated with deficient practice identified at "D" level.			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		
	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 to the administrator or his designated representative and to other officials in accordance			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Tucker RN — TITLE: DON — (X6) DATE: 9-21-15

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 225	Continued From page 1 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, review of the facility's investigation, and review of the facility's policy, it was determined the facility failed to ensure an allegation of abuse was reported immediately to administrative staff for one (1) of four (4) sampled residents (Resident #1). On the morning of 07/24/15, State Registered Nurse Aide (SRNA) #1 reported to Licensed Practical Nurse (LPN) #2 that on 07/23/15 (the prior evening) SRNA #3 had told Resident #1 she was going to hit the resident in the face with the resident's "dirty diaper." SRNA #1 failed to report the allegation of abuse immediately to administrative staff. The findings include: Review of the facility policy titled "Resident Abuse Policy," revision date 06/25/14, revealed the facility upheld the residents' rights to be free from abuse and strictly prohibited verbal, sexual, physical, and mental abuse. All allegations of abuse would be reported and thoroughly investigated. The policy further revealed all allegations involving mistreatment, neglect, or abuse would be reported immediately to the facility Administrator, Director of Nursing (DON), and the state agencies. Review of the medical record for Resident #1	F 225		

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F 225	Continued From page 2 revealed the facility admitted the resident on 04/17/14 with diagnoses that included Cerebral Vascular Accident (CVA), Depression, and Hypertension. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of the facility's final investigation, dated 07/30/15, revealed on the morning of 07/24/15, SRNA #1 reported to LPN #2 that on the evening of 07/23/15 SRNA #1 and SRNA #3 had changed Resident #1 and was assisting the resident back into the resident's wheelchair. The investigation further revealed SRNA #3 made a statement to Resident #1 that she would smack the resident in the face with the resident's dirty diaper; however, SRNA #3 then stated to the resident she was just joking. Further review of the investigation revealed Resident #1 thought SRNA #3 was going to slap the resident in the face with a dirty diaper. Continued review of the investigation revealed Resident #1 revealed he/she felt upset over the statement and denied that SRNA #3 had physically harmed the resident. An investigation of the incident was initiated immediately when reported (the morning after the incident occurred) and SRNA #3 was escorted to a non-resident care area and removed from the schedule. Review of the social services statement, which contained Resident #1's witness statement, dated 07/24/15, revealed when the resident was asked if anyone had said anything "out of the way" to the resident, the resident stated "yes" and the resident said "that girl" said she was going to smack him/her in the face with his/her dirty "diaper." The statement further revealed the	F 225		

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F 225	Continued From page 3 resident stated he/she felt that SRNA #3 was serious because the SRNA came back into the resident's room and begged the resident to not tell about the incident. Review of the investigation revealed the facility failed to substantiate or unsubstantiate the allegation due to differing statements from SRNA #1 and SRNA #3; however, SRNA #3 was terminated due to circumstances of the incident. Interview on 08/12/15 at 12:55 PM with Resident #1 revealed the resident did have a problem with "a girl" saying something mean to him/her and identified the girl as SRNA #3. The resident further revealed "the girl" told the resident she was going to slap the resident in the face with the resident's dirty "diaper" and it hurt the resident's feelings that someone would say something like that. Resident #1 further revealed "the girl" had not been back to work since the incident. Continued interview revealed Resident #1 did not tell the staff about the incident because the girl asked the resident not to tell because the staff person would get in trouble. Interview on 08/12/15 at 1:21 PM with SRNA #1 revealed SRNA #1 and SRNA #3 changed Resident #1 and transferred the resident back to the resident's wheelchair on 07/23/15. SRNA #1 stated that SRNA #3 told Resident #1 she was going to hit the resident in the face with "that dirty diaper." The interview further revealed Resident #1 stated to SRNA #3, "If you hit me with my diaper you will be looking for a new job." SRNA #1 felt like the statement made to Resident #1 was inappropriate and needed to be reported; however, the SRNA thought she had 24 hours to report abuse allegations so the SRNA reported the incident the next morning to the nurse.	F 225		

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F 225	Continued From page 4 Interview on 08/12/15 at 5:09 PM with SRNA #3 revealed SRNA #3 and SRNA #1 changed Resident #1 and transferred the resident back to the resident's wheelchair on 07/23/15. SRNA #3 stated that Resident #1 stated, "I thought you were going to hit me in the face with my dirty diaper." SRNA #3 revealed she informed Resident #1 no one was going to hit the resident with a dirty diaper, left the room to throw away the supplies from changing the resident, and never re-entered the room. The SRNA denied making any inappropriate comments to the resident. Interview on 08/12/15 at 1:53 PM with LPN #2 revealed that on the morning of 07/24/15 SRNA #1 reported that something had been bothering her and that the previous evening SRNA #3 had told Resident #1 she was going to hit the resident in the face with a dirty diaper. The interview further revealed LPN #2 immediately started the investigation, reported the allegation to administrative staff, and pulled SRNA #3 off the floor. LPN #2 revealed she interviewed Resident #1 and the resident reported the incident had happened and that SRNA #3 had asked the resident to not tell anyone about the incident. Interview on 08/12/15 at 2:24 PM with the Quality Assurance Registered Nurse (QARN) revealed when the incident was reported, SRNA #3 was immediately removed from resident care, the incident was immediately investigated, and witness statements were obtained from Resident #1 and staff. The interview further revealed SRNA #1 should have reported the incident immediately and had been trained to report allegations of abuse immediately.	F 225		

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F 225	Continued From page 5 Interview on 08/12/15 at 4:00 PM with the Director of Nursing (DON) revealed SRNA #1 should have reported the incident immediately. The interview further revealed as soon as the administrative staff was made aware of the allegation the residents were protected and an investigation was initiated. Continued interview revealed the facility did not substantiate or unsubstantiate the allegation due to the different statements given about the incident by SRNA #1 and SRNA #3, but stated that SRNA #3 was terminated due to the incident.	F 225	Please See Attachment #6 #7 #2	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT 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, review of the facility's investigation, and review of the facility's policy, it was determined the facility failed to assure the abuse policy outlined procedures to assure all investigations had a final finding of substantiated or unsubstantiated in order for substantiated incidents to be reported to agencies as required. On the morning of 07/24/15, State Registered Nurse Aide (SRNA) #1 reported to Licensed Practical Nurse (LPN) #2 that on 07/23/15 (the prior evening) SRNA #3 told Resident #1 she was going to hit the resident in the face with the resident's dirty diaper. Although the facility investigated the allegation, the facility	F 226	Please See Attachment 3A 3B 3C	

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F 226	Continued From page 6 failed to determine a finding of substantiated or unsubstantiated based of the findings of the investigation. The findings include: Review of the facility policy titled "Resident Abuse Policy," revision date 06/25/14, revealed the facility upheld the residents' rights to be free from abuse and strictly prohibited verbal, sexual, physical, and mental abuse. All allegations of abuse would be reported and thoroughly investigated. The policy further revealed all allegations involving mistreatment, neglect, or abuse would be reported immediately to the facility Administrator, Director of Nursing (DON), and the state agencies. Further review of the policy revealed all results of an internal investigation would be faxed within five (5) working days to the appropriate state agencies, but did not include how to determine the results and make a determination of substantiated or unsubstantiated. Review of the medical record for Resident #1 revealed the facility admitted the resident on 04/17/14 with diagnoses that included Cerebral Vascular Accident (CVA), Depression, and Hypertension. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of the final investigation, dated 07/30/15, revealed on the morning of 07/24/15, SRNA #1 reported to LPN #2 on the evening of 07/23/15 SRNA #1 and SRNA #3 changed Resident #1 and	F 226		

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F 226	Continued From page 7 was assisting the resident back into the resident's wheelchair. The investigation further revealed SRNA #1 reported SRNA #3 made a statement to Resident #1 that she would smack the resident in the face with the resident's dirty diaper; however, SRNA #3 then stated to the resident she was just joking. Further review of the investigation revealed SRNA #3 stated Resident #1 made the statement that the resident thought SRNA #3 was going to slap the resident in the face with a dirty diaper and SRNA #3 denied making any inappropriate statements to the resident. The investigation revealed the abuse committee met on the incident and determined the incident would not be substantiated or unsubstantiated due to the difference in the statements by the reporting SRNA (SRNA #1) and the involved SRNA (SRNA #3). Continued review of the investigation revealed that although the allegation was neither substantiated nor unsubstantiated, SRNA #3 was terminated from employment related to the circumstances of the incident. Interview on 08/12/15 at 2:24 PM with the Quality Assurance Registered Nurse (QARN) revealed the allegation was immediately investigated when the allegation was reported. The interview further revealed the facility did not substantiate or unsubstantiate the allegation due to the differing statements of SRNA #1 and SRNA #3. Continued interview revealed the facility staff felt it was "strange" that SRNA #1 did not report the allegation until the day after the allegation occurred and Resident #1 did not report the allegation until specifically asked about the allegation. Interview on 08/12/15 at 4:00 PM with the Director of Nursing (DON) revealed all allegations	F 226		

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F 226	Continued From page 8 of abuse were talked about in the Quality Assurance Meeting prior to substantiating or unsubstantiating the allegation to ensure all areas of concern were addressed. The interview further revealed the facility did not determine the allegation was substantiated or unsubstantiated due to the different statements given about the incident by SRNA #1 and SRNA #3.	F 226		