

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

PRINTED: 04/06/2012
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 03/23/2012
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 An abbreviated survey (KY #17979) was conducted on 03/21/12 through 03/23/12 to determine the facility's compliance with Federal requirements. KY #17979 was substantiated with deficiencies cited at the highest scope and severity of a "D."	F 000		
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 and review of the facility's policy/procedure, it was determined the facility failed to implement written policies and procedures that prohibit abuse mistreatment, neglect and abuse, related to the failure to investigate a resident to resident incident involving two residents (#1 and #2), in the selected sample of six residents. On 03/02/12 at approximately 6:30 PM, Resident #2 was heard to verbalize, "I'm going to kill [him/her], get [him/her] out of here," in reference to Resident #1 (roommate). Resident #1 was moved from the room and placed in another room temporarily during the week-end (03/03-04/12). Social Service documentation, on 03/05/12 at 3:38 PM, revealed, on 03/02/12, Resident #1 was temporarily moved to Room 101 because he/she was afraid to stay in the room with Resident #2, and stated "I hope he doesn't jump on me." On 03/05/12, Resident #1 was moved to Room 308	F 226	\$226 Corrected action was taken on 03/02/12 at which time resident #1 was removed from room 106 where he resided with resident #2. This move was done to protect resident # 1 from other threats from resident #2. Resident #1 was never placed back in room 106 with resident #2. All residents in the facility has the potential to be affected by the deficient practice due to the fact that a resident could either be the perpetrator or the victim in resident to resident abuse. Measures/systemic changes to be put into place are as follows: Resident to resident altercations will be documented on a standardized report form uniformly applied to each resident to resident altercation. This will ensure that a system is in place to record each incident consistently. The report will be made in private and away from work areas in order that all information reported is understood by	04/30/12

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

Jennifer H. Conell

TITLE

Administrator

(X6) DATE

04-12-12

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 226	<p>Continued From page 1 with a new roommate.</p> <p>Findings include:</p> <p>Review of the facility's "Policy Regarding Abuse," dated 09/03/08, revealed, "any suspected abuse of a resident was to be reported immediately to the administrator or designee in the absence of the administrator. The administrator or designee would conduct an investigation of the alleged abuse and report the incident to the appropriate agencies in accordance with State and Federal regulations." Review of the facility's policy and procedure, "Abuse Prevention", dated 09/03/08, revealed "abuse could be verbal, sexual physical, mental, corporal punishment, and involuntary seclusion. Further review revealed verbal abuse included saying things to frighten a resident, a loud, condescending tone of voice, or saying unkind things to a resident.</p> <p>A record review revealed the facility admitted Resident #1 on 04/18/11 with diagnoses to include Mental Retardation, Alzheimer's Disease, Schizophrenia, Hypothyroidism, Diabetes, Benign Prostatic Hypertrophy, Osteoporosis, Chronic Pulmonary Obstructive Disease, Gastritis and Anemia. Further review revealed no previous history of sexually inappropriate behaviors.</p> <p>A review of the annual Minimum Data Set (MDS), dated 02/17/12, revealed the facility assessed Resident #1 to be cognitively impaired, with no behaviors, and requiring extensive assistance of one staff for bed mobility, transfers, toileting and ambulation. The resident was frequently incontinent of bowel and had a supra-pubic catheter.</p>	F 226	<p>the receiver. Note that the receiver of the report will either be the administrator, the Director of Nursing of the charge nurse on duty. Both the person reporting the allegation and the receiver of the report will both sign the report form so that there will be no misunderstanding of information. Signatures will acknowledge that the report contains complete information and further will attest to the fact that no information is being left out (the reporter is accurate in his/her report and the receiver has clarity and understanding).</p> <p>To monitor performance, the following will occur: Staff will be given education by April 30, 2012 regarding reporting patient to patient incidents/allegations of abuse. New hires will be educated during orientation. Subsequent inservices will be held at least annually to re-educate staff.</p> <p>To further monitor, report forms</p>	

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F 226	Continued From page 2 A review of the Comprehensive Care Plan, dated 04/29/11 and updated on 03/06/12, for Impaired Cognitive Function, Impaired Thought Processes and Impaired Communication related to Alzheimer's Dementia, Mental Retardation and Schizophrenia, addressed inappropriate sexual behaviors and included interventions to place the resident in a room without a roommate, monitor and document [his/her] behaviors, and 1:1 supervision from 7:00 AM to 7:30 PM. On 03/08/12, a stop sign across the door when a sitter was not present was added to the care plan, and on 03/19/12, a door sensor alarm was added to the care plan. A record review revealed the facility admitted Resident #2 on 08/24/09 with diagnoses to include Diabetes, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Insomnia, Dementia with Delusions, Anxiety and Depression. A review of the quarterly MDS, dated 01/15/12, revealed the facility assessed Resident #2 to be severely cognitively impaired with physical behavioral symptoms directed toward others. The resident was incontinent of bowel and bladder and required extensive assistance of two staff for bed mobility, transfers, and toileting. He/she required extensive assistance of one staff for dressing, eating and personal hygiene. A review of the Comprehensive Care Plan, dated 01/27/11, revealed Impaired Cognitive Function related to a diagnosis of Dementia with agitated features, Depression, short-term memory deficit, and delusions. Further review revealed the resident was resistive to care and was verbally,	F 226	will be monitored by numbering each one. The forms will be kept in one specific location available at all times. Completed forms are to be routed to the administrator and will be kept in chronological order in administrator's office. This will ensure that consecutive reports are present with no gaps in numbered reports which could indicate a missing report. The administrator or designee in administrator's absence will check both the report book containing completed reports and/or report documents which are blank to ensure that all forms are in numerical order and accounted for. This check will be documented weekly. Reports will be given to the Quality Assurance Committee to ensure effectiveness and compliance.	

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F 226	<p>Continued From page 3</p> <p>physically and socially inappropriate with the staff at times.</p> <p>An interview with Certified Nurse Aide (CNA) #2, on 03/21/12 at 4:15 PM, revealed she had not observed any sexually inappropriate behaviors from Resident #1; however, she had observed Resident #2 point at Resident #1 and tell him/her to stay away from his/her bed and not to be trying to pull down his/her "britches." She stated she always reported the comments to the nursing staff. She stated, on 03/02/12, she again reported comments to the Charge Nurse when Resident #2 was "threatening to kill" Resident #1 if the staff did not remove him/her from the room. CNA #2 stated nursing staff felt the incident was related to Resident #2's history of behaviors. On 03/22/12 at 2:10 PM, she stated Resident #2 had a history of frequently making false accusations about others grabbing his/her pants and never wanted to be undressed.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 03/22/12 at 10:04 AM, revealed, on 03/02/12 at approximately 6:30 PM, he was at the medication cart when he heard yelling, and CNA #2 came to him and told him "something was wrong" with Resident #2. CNA #2 told him that Resident #2 was upset and would not allow the staff to undress him/her or provide personal care. LPN #1 stated when he went to Resident #2's room, the resident was in the bed, and told him that he/she was "going to kill" Resident #1, and to get him/her out of the room. He explained to Resident #2 that Resident #1 lived in the room also; however, Resident #2 said he/she did not care and kept saying he/she wanted Resident #1 out the room repeatedly. He stated Resident #2</p>	F 226		

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F 226	<p>Continued From page 4</p> <p>had a history of catastrophic outbursts. He stated Resident #1 was in a wheelchair by the door and was "shaking," so he removed him/her from the room to a place of safety. He stated Resident #1 stated he/she did not want to go back in the room with Resident #2. He stated he was never told anything about Resident #2's complaints about Resident #1 pulling back his/her covers or pulling down his/her pants. When LPN #1 was asked if he initiated an investigation, he stated he moved Resident #1 to a place of safety and passed the information on to the next shift.</p> <p>An interview with the Director of Nursing (DON), on 03/23/12 at 11:00 AM, revealed prior to 03/21/12, she had no knowledge of Resident #1 "messaging with" Resident #2. She stated there was an abuse training in February 2012 and the policy was reviewed. Additionally, less obvious forms of abuse were discussed. She expected to be notified if Resident #1 was suspected of touching Resident #2.</p> <p>An interview with the Administrator and the DON, on 03/23/12 at 3:30 PM, revealed Resident #2 had a history of behaviors to include delusions and made threats against the staff and family. Resident #2 was very modest and never liked anyone removing his/her clothes. He/she was having outbursts, which was associated with fluid overload and deoxygenation. The Administrator stated she did not see the incident, on 03/02/12, as a willful intent to harm Resident #1, as this was not uncharacteristic behavior for Resident #2.</p>	F 226		
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