

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



PRINTED: 11/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/14/2012
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	
(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 On 11/14/12, an onsite revisit to the abbreviated survey (10/24-29/12) was conducted which determined Immediate Jeopardy (IJ) had been removed at 42 CFR 483.13 Resident Behavior and Facility Practices, F-223, F-226; and 483.75 Administration, F-490, on 10/28/12 as alleged in the acceptable Allegation of Compliance (AoC) received 11/09/12. While the IJ was removed at F-223, F-226, and F-490, continued non-compliance remained as follows: F-223, F-226, and F-490 at the S/S of a "D." The facility had not completed the development of a plan to ensure correction of the deficient practice to prevent recurrence.	{F 000}	The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 10/28/2012.	
{F 223} SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 10/29/12, had been removed. However, non-compliance continued to exist as the facility's Quality Assessment and Assurance Committee (QAAC) had not fully implemented a plan of correction to prevent recurrence of the deficient practice related to staff knowledge of the facility's	{F 223}	F223 Free From Abuse/Involuntary Seclusion 1. Resident #1 was removed from the incident on 10/09/12. Care plan was updated to allow resident to leave the dining area when desired. 2. All resident have potential to be affected. 3. Immediate Jeopardy was abated on 10/28/12 with revision five of the Allegation of Compliance attached. In addition, education for all staff began on 10/25/12 from the Administrator or Director of Nursing regarding the facility policy and procedure of abuse/neglect preventions, investigation, resident protection and reporting guidelines to include the resident right to be free from	

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

Jammy Workman

TITLE

Administrator

(X6) DATE

12/6/12

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 223}	Continued From page 1 Abuse/Neglect and Prevention, Investigation, Resident Protection, and Reporting policies and procedures. Findings include: Review of the acceptable Allegation of Compliance (AoC), dated 11/09/12, revealed all residents were assessed for bruising, injuries, and behavior changes on 10/25/12. The assessments were completed by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Registered Nurse (RN) unit manager, Licensed Practical Nurse (LPN) unit manager, and 600 unit LPN after being trained by the Regional Director of Operations (RDO). The Director of Social Services spoke to 22 interviewable residents and 52 family members related to abuse/neglect in the facility and ensured they were aware of how to report. All staff received education on the facility's Abuse and Neglect policy as well as recognition of "stressed staff." To verify understanding, the staff completed a post competency test related to all aspects of the abuse and neglect policy and expectations. The test was given by the DON, Administrator, Human Resources Director, or Social Services Director. Any staff not achieving 100% was provided re-education by the DON or Administrator and retested. To ensure all residents, staff, families, and vendors were aware of what to do if abuse was suspected, new signs in general viewing areas were placed to indicate the facility as an abuse free zone. The facility developed and implemented verification sheets to document rounds every two hours by the Compliant Officer. The rounds consist of visualizing each resident every two hours to	{F 223}	Verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. No staff member worked until receiving education from the Administrator or Director of Nursing. New staff has received education from the Administrator or Director of Nursing before starting their first shift. One staff member is on FMLA and will not work their shift until educated by either the Administrator or Director of Nursing. The facility will ensure that the staff understands the policy and procedure of abuse/neglect and prevention, investigation, resident protection, and reporting; and staff must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion through direct staff interviews done daily by department heads. 4. Compliance for this will be monitored on seven days a week by collecting the suspected abuse monitoring forms by Administrator/Director of Nursing or department head. Findings from Department head interviews will be discussed in morning meetings and documented on the daily Continuous Quality Improvement forms. Findings will be maintained by Administrator and reported in Continuous Quality Improvement meetings each month. 5. Date of compliance is	11/15/12	

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{F 223}	Continued From page 2 observe for potential signs of abuse.	{F 223}	F226 Develop/Implement Abuse/Neglect, etc policies		
{F 226} SS=D	<p>An interview with the Administrator, on 11/14/12 at 1:20 PM, revealed the facility had not submitted an acceptable Plan of Correction (PoC).</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey (10/24-29/12) had been removed related to the written policies and procedures that prohibited abuse of residents related to the prevention, investigation, resident protection, and reporting abuse. However, non-compliance continued to exist at the S/S of a "D" as the facility had not developed and implemented a Plan of Correction (PoC) as related to the prohibited abuse of residents.</p> <p>Findings include: A review of the acceptable Allegation of Compliance (AoC), dated 11/09/12, and the inservicing records and signatures, revealed all staff were inserviced on the Abuse and Neglect Policy and the recognition of "stressed staff" by</p>	{F 226}	<p>1. Resident # 1 was removed from the incident on 10/09/12. Abuse registry checks and background checks were completed/initiated on 10/26/12 on the eight employees filed identified.</p> <p>2. All resident have the potential to be affected.</p> <p>3. Immediate Jeopardy was abated on 10/28/12 with revision five of the Allegation of Compliance attached. In addition, staff was education by the Administrator or Director of Nursing on the facility's policies that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property, beginning on 10/25/12 with no staff working until receiving this education. New hires will be screened for history of abuse, neglect or mistreating residents to include abuse registry checks, background checks and will be verified by the Administrator prior to working their first shift. The facility will ensure that the staff understands the policies that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property through direct staff interviews done daily by department heads.</p> <p>4. Compliance for this will be monitored on seven days a week by collecting the suspected abuse monitoring forms by Administrator/Director of Nursing or department head. Findings from</p>		

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{F 226}	Continued From page 3 the Director of Nursing (DON) and Administrator. The Licensed Practical Nurse (LPN) unit manager received one on one training by the Regional Director of Operations (RDO), on 10/25/12, that focused on the immediate removal of "alleged perpetrator" from resident care areas and "stressed staff." The DON and 600 hall evening shift Registered Nurse (RN) were inserviced on 10/26/12 regarding re-entry into the facility for "alleged perpetrators." A Compliance Officer was assigned every shift to ensure visual rounds on each resident every two hours, for potential signs of abuse. The DON retrieved the monitoring forms each morning (weekdays) for review, while a department head reviewed them on the weekends.	{F 226}	Department head interviews will be discussed in morning meetings and documented on the daily Continuous Quality Improvement forms. The administrator will maintain monthly audits of all new hires. Findings will be maintained by Administrator and reported in Continuous Quality Improvement meetings each month. 5. Date of compliance is	11/15/12
{F 490} SS=D	An interview with the Administrator, on 11/14/12 at 1:20 PM, revealed the facility had not submitted an acceptable Plan of Correction (PoC). 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy (IJ) identified during the survey, concluded on 10/29/12, had been removed. However, non-compliance continued to exist as the facility's Quality	{F 490}	F490 Effective Administration/Resident well-being 1. Resident #1 was removed from the incident on 10/09/12. 2. All residents have the potential to be affected. 3. Immediate Jeopardy was abated on 10/28/12 with revision five of the Allegation of Compliance attached. In addition, the Administrator and Director of Nursing was educated by the Regional Director of Operations on 10/25/12 on administering the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Administrator or Director of Nursing will ensure staff follow the abuse/neglect policy related to the prevention, investigation, resident protection, and reporting abuse by reviewing incidents for appropriate investigation and follow up to include appropriate notification of state agencies is done within appropriate	

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{F 490}	<p>Continued From page 4</p> <p>Assessment and Assurance Committee (QAAC) had not fully implemented a plan of correction to prevent recurrence of the deficient practice related to the failure to ensure staff followed the Abuse and Neglect policy related to the prevention, investigation, resident protection, and reporting abuse.</p> <p>Findings include:</p> <p>A review of the acceptable Allegation of Compliance (AoC), dated 11/09/12, revealed the Administrator and Director of Nursing (DON) was re-educated, by the Regional Director of Operations (RDO), on 10/25/12, in regard to the seven components of the Abuse and Neglect policy including the immediate reporting to a supervisor and the immediate removal of an "alleged perpetrator" from resident care areas. The facility would implement a monthly communication meeting with all staff that emphasized resident rights and prevention of abuse.</p> <p>An interview with the Administrator, on 11/14/12 at 1:20 PM, revealed the facility had not submitted an acceptable Plan of Correction (PoC).</p>	{F 490}	<p>time frames and alleged perpetrators are immediately removed from the facility. Incidents will be reviewed and discussed each day in the morning meetings Monday thru Friday. Any incident on Saturday or Sunday will be communicated to the Administrator or Director of Nursing immediately for appropriate investigation.</p> <p>4. The Administrator and/or Director of Nursing will document each day on Continuous Quality Improvement forms review of the previous days 24hr reports for any signs or documentation indicating abuse/neglect suspicions. Any reported allegations will also be reviewed/investigated appropriately by the Administrator and/or Director of Nursing. The weekend department head will document on the Continuous Quality Improvement forms for weekends. All allegations will be logged on the Administrators monthly abuse/neglect log and reviewed during the monthly Continuous Quality Improvement Meetings.</p> <p>5. Date of compliance is</p>	11/15/12	