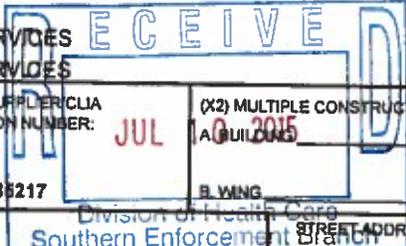


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188217	(X2) MULTIPLE CONSTRUCTION A. BUILDING NO. _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2015
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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129
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(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	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
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 to the administrator or his designated representative and to other officials in accordance	F 225	1. The allegation of abuse for resident #1 was unsubstantiated by the OIG and the facility. A PHQ9 mood interview was completed on resident #1 by the Social Service Director on 6/12/15 to determine if there was any change in mood related to the reported allegation. There was no change identified. 2. Interviews have been conducted by the Social Service Director/DON/ADON with 10 interviewable residents on the same unit as resident #1 to determine if there were any concerns related to care provided by any staff. There were no concerns reported. The skin assessments for the non-interviewable residents on the same unit as resident #1 were reviewed by the DON/ADON on 7/7/15 to determine if there were any injuries of unknown origin. There were none identified. 3. The Administrator, Social Service Director, DON, and ADON have received in-service education on compliance with the facility abuse policy as provided by the contracted Nurse Consultant on 7/7/15, including, but not limited to: identification of events requiring investigation; and removal of any identified staff from the resident direct care area and/or the facility until the conclusion of the investigation to protect the residents. 4. The CQI indicator for the monitoring of compliance with the facility abuse policy will be utilized monthly X2 months and then quarterly thereafter	7/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>W. Neighbor</i>	TITLE Administrator	(X8) DATE 7/8/15
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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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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 781 SKYLINE DRIVE EDMONTON, KY 42129		
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F 225	<p>Continued From page 1</p> <p>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 facility's investigations and abuse policy, it was determined the facility failed to protect residents of the facility when an allegation of abuse was reported and an investigation was initiated. The abuse allegation was reported on 06/11/15 at 10:15 AM to the Assistant Director of Nursing (ADON) concerning two (2) staff members that "held down" Resident #1 and would not help her. Resident #1 was unable to remember the staff members' names; however, a description of the staff members was given to the facility. The two (2) staff members were identified on 06/11/15 at 11:30 AM. The facility failed to ensure the safety and protection of Resident #1 and other residents of the facility by not removing Certified Medication Technician (CMT) #1 and CMT #2 from the facility pending the investigation, according to the facility's Abuse Policy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect and Exploitation," not dated, revealed in case of alleged abuse involving an employee against a resident, the employee would be suspended pending further investigation by the Administrator.</p>	F 225	as per the CQI calendar, by the Administrator or Social Service Director. Findings below the required threshold of 100% will result in a plan of correction to address the identified areas. The indicator includes but is not limited to the monitoring of: reporting all allegations of abuse, removal of staff identified in an allegation from the resident direct care area and/or facility to protect the residents; and thorough investigation of all allegations of abuse.		

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F 225	<p>Continued From page 2</p> <p>Record review revealed the facility admitted Resident #1 on 04/07/15 with diagnoses that included Anxiety, Depressive Disorder, Congestive Heart Failure, Respiratory Failure, and Chronic Airway Obstruction. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment dated 04/14/15 revealed the resident was interviewable with a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #1 was cognitively intact.</p> <p>Interview with Resident #1 on 06/17/15 at 1:15 PM revealed the resident stated, "The two girls held me down; I couldn't breathe, and I was scared."</p> <p>Interview with the ADON on 06/17/15 at 3:30 PM revealed she immediately began an investigation after she was made aware of the alleged abuse. She stated after she and the Director of Nursing (DON) completed all staff interviews, they concluded that Resident #1 had a "panic attack" and no abuse had taken place. She further stated that since they concluded that no abuse had taken place, there was no need to suspend CMT #1 or CMT #2.</p> <p>Interview with the DON on 06/17/15 at 3:15 PM revealed the facility had never received a complaint on CMT #1 or CMT #2 concerning abuse and after the investigation was over she did not believe this was an incident of abuse and the named staff in the incident did not need to be removed from the facility.</p> <p>Interview with the Administrator on 06/17/15 at 2:55 PM revealed she and the DON were responsible for starting the investigations when allegations of abuse were made. She further</p>	F 225			

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F 225	Continued From page 3 revealed she was not in the building when the alleged abuse complaint was reported; however, she was notified of the incident. The administrator stated, "If we think staff is truly being abusive then yes, we remove the staff from the facility."	F 225			
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, personnel record review, and review of facility policy, it was determined the facility failed to ensure criminal record checks were requested upon hire for one (1) of five (5) personnel records reviewed (Employee #1). The findings include: Review of the facility's policy, "Abuse, Neglect, and Exploitation," not dated, revealed criminal record checks would be conducted on all employees. Review of the personnel record on 06/17/15 at 6:00 PM for Employee #1, revealed the employee's hire date was 11/27/03. Further review of the personnel record revealed no evidence that the facility conducted a Criminal Record Check to ensure the employee did not have a past criminal record.	F 226	1. The criminal record check has been completed for employee #1 and placed in the employee file. 2. All current employee files have been audited by the Accounts Payable/Payroll Clerk on 6/18/15 to determine that criminal record checks were obtained upon hire and are present in the file. All files contain criminal record checks. 3. The Accounts Payable/Payroll Clerk will have the department head over each new hire to sign the criminal record check when it is obtained, to verify that this has been completed upon hire. In-service education has been provided by the Administrator on 7/7/15 for the Accounts Payable/ Payroll Clerk and department heads on this new process. 4. The CQI Indicator for the monitoring of employee files for criminal record checks will be utilized monthly X2 months, and then quarterly thereafter as per the established CQI calendar under the supervision of the Administrator.	7/8/15	

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F 226	<p>Continued From page 4</p> <p>Interview with the Accounts Payable/Payroll Clerk on 06/17/15 at 6.50 PM, revealed she was responsible for completing criminal checks on all new employees. However, she stated she did not start in that job position until 01/03/05 and Employee #1's hire date was 11/27/03.</p> <p>Interview with the Administrator on 06/17/15 at 7:00 PM, revealed all new employees should have Criminal Record Checks completed.</p>	F 226		
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