

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186437 OCT 18 2015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/01/2015
NAME OF PROVIDER OR SUPPLIER THE VILLAGE OF LEBANON II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 105 VILLAGE WAY LEBANON, KY 40033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	<p>The preparation an execution of this plan does not constitute admission or agreement by the provider of truth of facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because it is required by federal law.</p> <p>On 8/11/15 all residents cared for by alleged staff member on the evening of 8/10 and 8/11 were interviewed with no issues identified Resident #1 was interviewed as noted in statement. Resident voiced no further concerns related to the alleged incident.</p> <p>All facility residents were interviewed on 8/11/15 with no issues identified. No non-verbal residents were in the facility. Residents who did not appear to understand questions during interview were assessed and monitored for any non-verbal cues, flinching, injuries of unknown origin and increased anxiety and or withdrawal.</p>	8/11/2015

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

Linda Ross

TITLE

Administrator

(X8) DATE

10/18/15

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	<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:</p> <p>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 immediately reported to administrative staff for one (1) of three (3) sampled residents (Resident #1), and failed to immediately remove Certified Nursing Assistant (CNA) #1 from direct care duties to protect the residents. On 08/10/15, at approximately 11:30 PM, Resident #1 reported to the Charge Nurse that CNA #1 had "treated (him/her) like a dog," and "threw" his/her positioning device onto the floor. However, the Charge Nurse failed to report the allegation to administrative staff and failed to remove CNA #1 from direct resident care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse," revised 01/10/13, revealed if an allegation of resident abuse by an employee was reported to the Charge Nurse, the employee would be sent home pending the investigation. The policy also stated the Charge Nurse would immediately report the allegation to the Administrator, Social Services Director, and the Director of Nurses or designee.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on</p>	F 225	<p>SRNA #1 was immediately suspended upon reports of event by resident to social services director on 8/11/2015, employment was terminated after due to her attitude with management and previous attitude with management (with counseling noted). RN#1 was immediately suspended upon residents report of events to social service director on 8/11/2015. During interview with RN, and prior to facility establishing resolution for her, she terminated her employment with the facility.</p> <p>Resident abuse reporting inservice was conducted with all staf begining on 8/12-8/26/15 by company staff development coordinator. Further inservicing was initiated for RN's & LPN's beginning on 9/2/15 which further detailed the nurses essential job functions when dealing with alleged abuse. All facility nurses were required to attend inservices on 9/2-9/4</p>	9/4/15	

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F 225	<p>Continued From page 2</p> <p>04/07/14 with diagnoses that included Atrial Fibrillation, Diabetes Mellitus, and Cholecystitis. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 07/03/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had no cognitive impairment.</p> <p>Review of a facility investigation dated 08/14/15, revealed on 08/11/15, Resident #1 reported to the facility's Social Services Director (SSD) that on 08/10/15 at approximately 11:30 PM, he/she had activated the call light for assistance to have his/her positioning wedge cushion removed. Resident #1 reported that when CNA #1 entered the resident's room, the CNA informed Resident #1 that he/she still had thirty minutes left to lie in that position before being repositioned and exited the room. Resident #1 reported that he/she then immediately reactivated the call light, and when CNA #1 entered the room she removed the cushion from underneath the resident, and "threw" it onto the floor. Resident #1 reported to the SSD that he/she told CNA #1 that he/she was going to report her behavior to her supervisor, and CNA #1 "stuck her tongue out" at the resident as she exited the resident's room. The investigation revealed the SSD immediately initiated an investigation into the allegation. The facility's investigation revealed that Resident #1 did report CNA #1's behavior to the Charge Nurse on 08/10/15; however, the Charge Nurse failed to remove CNA #1 from direct resident care or report the allegation to the Administrator, SSD, or the DON as required.</p> <p>Interview with Resident #1 on 09/01/15, at 1:05 PM, revealed the resident was able to recall the</p>	F 225	<p>Nurses were re-educated on abuse and policy to notify Administrator, DON, and SSD in the event of any alleged abuse. Social Service Director and Administrator will interview 10% of residents each week regarding any care concerns including questions pertaining to: meeting their needs, friendly staff, and mistreatment. Any issues identified will be immediately corrected following facility policy. Non-verbal residents or those that may not understand questions will be monitored for non-verbal cues, including: flinching, injuries of unknown origin, increased anxiety and withdrawal. Interviews/monitoring will continue weekly x 1 month and if no issues are identified, interviews will continue at a rate of 10% per month x 5 months. Staff will be re-educated on abuse and abuse reporting with each Town Hall or staff meetings that occur at least quarterly.</p>	9/4/2015	

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F 225	<p>Continued From page 3</p> <p>events of 08/10/15. Resident #1 recounted that he/she had requested CNA #1 to provide assistance with the positioning device, but that she initially refused to assist the resident, and then ultimately threw the positioning device onto the floor. Resident #1 stated he/she "did not want to hold anything against (CNA #1)" and that he/she had been upset at the way CNA #1 had treated him/her at the time, but had not been harmed or affected by the incident.</p> <p>Interview with the Charge Nurse on 09/01/15, at 1:50 PM revealed that CNA #1 came out of Resident #1's room on 08/10/15, at approximately 10:45 PM and stated she was not going back into Resident #1's room, because the resident was cursing and pointing his/her finger at the CNA. The Charge Nurse stated she immediately went to Resident #1's room. The Charge Nurse stated that Resident #1 was upset and stated that CNA #1 "had treated (him/her) like a dog." The Charge Nurse stated that Resident #1 had told her that CNA #1 had initially refused to assist him/her with the wedge cushion, and after ringing the call light again, CNA #1 removed the cushion and "threw" it onto the floor. The Charge Nurse stated she instructed Resident #1 to talk to the facility's SSD in the morning, and she would take care of the situation. The Charge Nurse stated she then assigned another CNA to care for Resident #1, leaving CNA #1 to care for all of her other assigned residents and complete the shift, which ended at 7:00 AM on 08/11/15. The Charge Nurse stated that she had been trained on and was aware of the facility's abuse policy and stated, "I know I should have sent her home," but did not because she believed the situation had been resolved once Resident #1 was reassigned to another staff member. The Charge</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>Nurse stated that she also failed to notify any administrative staff of the incident, including the DON who came into the facility on 08/11/15, at 3:00 AM to provide coverage for another nurse on another unit in the facility.</p> <p>Interview with the DON on 09/01/15, at 2:30 PM confirmed she came to the facility on 08/11/15, at 3:00 AM and stayed for the remainder of the shift, but that the Charge Nurse did not report the incident that had occurred with Resident #1 and CNA #1 to her.</p> <p>Attempts to contact CNA #1 for interview on 09/01/15 at 12:03 PM, 1:58 PM, and 3:28 PM were unsuccessful. However, a review of a statement obtained from CNA #1 by the facility dated 08/11/15, revealed she had spoken to Resident #1 in a "loud voice" and "threw" the resident's positioning cushion onto the floor after the resident had continued to activate the call light to have the cushion removed.</p> <p>Interview with the SSD on 09/01/15 at 3:10 PM revealed that she "just happened" to deliver Resident #1's breakfast or lunch tray (could not remember for sure which meal it was) to him/her on 08/11/15, and the resident reported to her the events that had occurred with CNA #1 the night before on 08/10/15. The SSD stated she immediately initiated an investigation and notified the Administrator.</p> <p>Interview with the Administrator on 09/01/15 at 3:17 PM, revealed that although the facility's investigation had not determined that CNA #1's actions toward Resident #1 constituted abuse, the facility determined the CNA's actions were inappropriate. The Administrator stated that CNA</p>	F 225			

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F 225	Continued From page 5 #1 had also been previously counseled for having an inappropriate attitude when dealing with authority figures in the facility. Therefore, CNA #1 was terminated from employment at the facility. The Administrator stated that the Charge Nurse resigned from employment at the facility when questioned as to why she did not follow the facility's abuse policy and procedure when Resident #1 reported the incident to her on 08/10/15.	F 225			