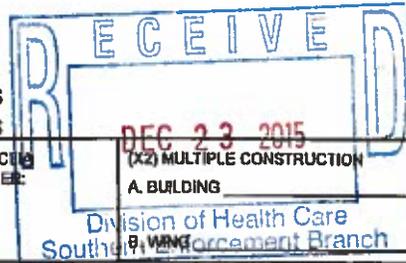


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/02/2015
FORM APPROVED
OMB NO. 0938-0391



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185103 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ C. WING _____ | (X3) DATE SURVEY COMPLETED C 11/16/2015 |
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| NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403 |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 225 SS=D | <p>489.13(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 Terrace Nursing and Rehabilitation Facility does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Terrace reserves the right to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it is responds, is not meant to establish any standard of care, contract obligation or position. The Terrace reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self examination privileges which The Terrace does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Terrace offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to our residents.</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Paula Long-Streck* TITLE: *Administrator* (X6) DATE: 12/23/15

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: Based on observation, interview, record review, facility policy review, and facility abuse investigation review, it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse were reported immediately to the administrator of the facility and to state agencies for one (1) of three (3) sampled residents (Resident #1). Interviews conducted with Resident #1, Resident #2, and Resident #1's family member revealed they had reported to Registered Nurse (RN) #2 on 11/07/15, that State Registered Nursing Assistant #1 had "thrown" Resident #1 on the bed and had injured the resident's foot. Resident #1's family member did not want SRNA #1 to provide care for Resident #1 in the future. However, interview conducted with the Administrator on 11/16/15, revealed she had not investigated the allegation because Resident #1 always complained of pain with any movement, and she had not considered the incident to be an allegation of abuse, therefore no investigation had been completed, SRNA #1 was allowed to continue working, and state agencies had not been notified of the incident.</p> <p>The findings include:</p> <p>Review of the facility's "Abuse Policy," dated 08/01/13, revealed the Administrator must be notified immediately of any suspected abuse or</p> | F 225 | <p>483.13(c)(1)(ii)-(iii),(c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>It is the policy of The Terrace Nursing and Rehabilitation Facility to ensure 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.</p> <p>On 11/7/15 SRNA #1 and RN #1 provided care to Resident #1. At no time did SRNA #1 go into Resident #1 room by themselves. Resident #1 requires assistance of two for care. Resident #1 is turned and repositioned every hour. Resident #1 does not get out of bed per their choice. SRNA #1 and RN #1 did not get Resident #1 out of bed at any time on 11/7/15. Resident #1 has documented and care planned behavior of ongoing hollering out, noncompliance with care and yelling/screaming at staff. Resident #1 is under psychiatric care for attention seeking behavior, dementia and delusions. Resident #1 is being treated with medication for his behavior.</p> | | |

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| F 225 | <p>Continued From page 2</p> <p>Incidents of abuse. The policy also revealed any individual observing an incident of abuse must immediately report the incident. The policy revealed all reports of resident abuse, neglect, and injuries of unknown origin would be promptly and thoroughly investigated by facility management and would be reported to state agencies as required.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 08/04/14, with diagnoses including Basal Cell Carcinoma, Dementia, and Contracture of the Left Knee.</p> <p>Review of an annual Minimum Data Set (MDS) assessment for Resident #1 dated 10/23/15, revealed Resident #1 was assessed by the facility to have a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident was interviewable. The MDS also revealed the resident required the total assistance of two staff persons for bed mobility and transfers.</p> <p>Review of the medical record for Resident #2 revealed the facility admitted the resident on 08/03/15, with diagnoses including Dementia and Anxiety.</p> <p>Review of an admission MDS assessment for Resident #2 dated 08/10/15, revealed Resident #2 was assessed by the facility to have a BIMS score of 11 which indicated the resident was interviewable.</p> <p>Observation of Resident #1 on 11/16/15, at 1:30 PM, revealed SRNA #4 and SRNA #5 were observed to turn and reposition the resident in bed. The resident was observed to moan as the</p> | F 225 | <p>Resident #2 shares a room with Resident #1. Resident #2 is under psychiatric care for mood disturbances, dementia and for fixed delusions of harm and illegal activities. On 11/7/15 Resident #2 had a documented psychiatric episode related to the belief that he is on the FBI Hit List. Resident #2 is being treated with medication for his behavior.</p> <ol style="list-style-type: none"> The noted Resident #1 and Resident #2 behaviors on 11/7/15 was previously assessed, documented and care planned. SRNA#1 was not in Resident #1 room at any time by themselves on 11/7/15. Both Resident #1 and Resident #2 received nursing and medical intervention directed by House Supervisor RN on 11/7/15 which is documented in their medical records. In addition, the facility initiated an investigation by interviewing staff, interviewing all interviewable residents on the unit, skin assessments were conducted of all residents on the unit and no additional concerns were found. On 11/16/15 and 11/23/15 interviews were conducted of all interviewable residents on the unit where Resident #1 resides and SRNA #1 works, as to whether SRNA #1 had ever been rough, rude or abusive in any way to them or anyone else at any time during their stay at the facility. The answers were unanimously "NO". | | |

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| F 225 | <p>Continued From page 3</p> <p>SRNAs moved the resident.</p> <p>Interview conducted with Resident #1 on 11/16/15, at 12:00 PM, revealed SRNA #1 "was not allowed back in my room because he hurt my foot when he turned me." The resident stated SRNA #1 had not been back in the resident's room since. Resident #1 could not recall SRNA #1 yelling.</p> <p>Interview conducted with Resident #2 (Resident #1's roommate) on 11/16/15, at 12:05 PM, revealed Resident #1 asked to be pulled up in bed and "that big boy came in here and said what in the hell do you want?" Resident #2 stated SRNA #1 then picked him/her up and threw him/her on the bed. Resident #2 stated Resident #1 yelled out "you hurt my foot." The resident stated SRNA #1 then went to get help. Resident #2 stated he/she told RN #1 what had happened.</p> <p>Interview conducted with SRNA #1 on 11/16/15 at 12:15 PM, revealed he was providing care for Resident #1 on 11/07/15, and at approximately 12:35 AM both he and RN #1 went into Resident #1's room to reposition the resident in bed. He denied that he yelled at the resident, or that he threw the resident in the bed. The SRNA stated the resident always complained of pain when turning him/her in bed. The SRNA stated he was required to immediately report any allegations of abuse or neglect.</p> <p>Interview conducted with RN #1 on 11/16/15, at 2:05 PM, revealed she had helped SRNA #1 to turn and reposition Resident #1 on 11/07/15, at approximately 12:30 AM. The RN stated Resident #1 always complained of pain with any movement. RN #1 stated Resident #1 had</p> | F 225 | <p>3. On 11/16/15, 11/23/15, and 12/3/15 and 12/4/15 educational inservices were conducted by the Director of Nursing and the Staff Development RN with facility SRNAs and nurses about the facility Resident Protection Policy. The inservicing contained specific direction on immediately reporting allegations of abuse and then investigating to determine if the abuse allegation is substantiated.</p> <p>4. On 12/10/15 an additional QA monitoring process was implemented by the Director of Nursing to help monitor for possible abuse allegations. Through daily (Monday -Friday) morning meetings where the Administrator, Director of Nursing, CQI Nurse, MDS Nurse, the Social Worker, administrative nurses and a therapy representative are usually present AND on the weekends when the House Supervisor RN is working...the team will continue to review incident reports, shift reports, monitoring logs and physician orders to identify potential incidents of abuse. The</p> | |

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| F 225 | <p>Continued From page 4</p> <p>complained that they were hurting him/her when they were moving the resident. The RN stated the resident complained of his/her left foot being hurt while they were moving him/her. The RN stated she had assessed the resident's foot and had not identified any injury. RN #1 stated Resident #2 told her SRNA #1 had thrown Resident #1 on the bed and hurt his/her foot, and had yelled at Resident #1. RN #1 stated she told Resident #2 that she had helped to turn Resident #1 and they had not hurt the resident's foot, nor had SRNA #1 yelled at Resident #1. The RN stated she then reported the allegations to RN #2 who was the house supervisor.</p> <p>Interview conducted with Resident #1's family member on 11/16/15, at 2:55 PM, revealed he came to the facility on 11/07/15, and was unsure of the time. The family member stated Resident #1 and Resident #2 both told the same story that SRNA #1 had thrown Resident #1 on the bed, hurt his/her foot, and then yelled at the resident. The family member stated he/she reported the incident to RN #2 and told her he/she did not want SRNA #1 back in Resident #1's room again. The family member stated he/she was told not to pay any attention to Resident #2 because the resident was just confused.</p> <p>Interview with RN #2 on 11/16/15, at 3:10 PM, revealed RN #1 had reported the allegations by Resident #1 and Resident #2 to her on 11/07/15. The RN stated she then went in to talk to Resident #1 and Resident #2. The RN stated Resident #2 reported to her that he/she had been awake all night watching to ensure SRNA #1 did not hurt Resident #1 again. RN #2 stated Resident #2 was very angry and agitated. The RN stated Resident #1 did not appear to be in</p> | F 225 | <p>documentation form that is already used for the meeting had a category for "abuse allegations" added to the form. On a monthly basis for the next six months a summary of the QA monitoring process findings will be presented during the QA Clinical meeting. Allegations of abuse will be reported immediately to the required state agencies.</p> <p>5. Corrective actions were completed on 12/11/15.</p> | 12/11/15 | |

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| F 225 | <p>Continued From page 5</p> <p>any increased pain. The RN stated Resident #1's family member came in and after the family talked with Resident #1 asked for SRNA #1 not to provide care for Resident #1 because the resident had told him/her SRNA #1 threw the resident on the bed, yelled at him/her, and hurt his/her left foot. RN #2 stated she notified the Administrator to report Resident #1's family member's concerns and was instructed by the Administrator to not let SRNA #1 provide care for Resident #1 and Resident #2. The RN stated the Administrator told her the family member was aware the resident experienced pain when he/she was moved.</p> <p>Interview with the Director of Nursing (DON) on 11/16/15, at 5:25 PM, revealed no investigation had been completed because this was a normal behavior for Resident #1. The DON stated Resident #1 always complained of pain with any movement. The DON stated both SRNA #1 and RN #1 were in the room when the alleged incident occurred.</p> <p>Interview conducted with the Administrator on 11/16/15, at 5:45 PM, revealed she was notified on 11/07/15, by RN #2 regarding Resident #2 having increased agitation requiring physician and family notification. The Administrator stated she was not notified of Resident #2's allegations and was told of Resident #1's family member not wanting SRNA #1 to provide care for the resident. The Administrator stated she was unaware of any allegations of abuse, but should have been. An investigation was required to be completed for any allegation and state agencies were to be notified. The Administrator stated RN #2 had taken witness statements but had not forwarded them to her, nor were any other residents or staff</p> | F 225 | | | |

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