

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

PRINTED: 08/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2014
NAME OF PROVIDER OR SUPPLIER BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345	
(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 investigating KY #21994 was conducted on 07/29/14 through 07/30/14 to determine the facility's compliance with Federal requirements. KY #21994 was substantiated with a deficiency cited at the highest S/S of a "D".	F 000		
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	F 225	F225 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The alleged incident revealed no harm occurred to the resident identified as #1 of this investigation. The Director of Nurses submitted an allegation of abuse on 7/14/14 and completed the investigation on 7/18/14. How will this facility identify other residents having the potential to be affected by the same deficient practice? All residents had the potential to be affected by the deficient practice.	8-19-14



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

[Handwritten Signature]

TITLE

Adm

(X5) DATE

8-19-14

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>representative and to other officials in accordance 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 investigation and Abuse and Neglect policy and procedure it was determined the facility failed ensure all non-interviewable residents who were cared for by the alleged perpetrator were assessed timely to ensure there were no injuries after one (1) of three (3) sampled residents (Resident #1) alleged Certified Medication Technician (CMT) #1 hit him/her on the buttocks with a bedpan. The facility only assessed three (3) of nine (9) non-interviewable residents on Resident #1's hall two (2) days after the alleged incident.</p> <p>The findings include:</p> <p>Review of the facility's policy "Abuse and Neglect Policy and Procedure", last updated 02/25/14, revealed a formal investigation would be performed by the Administrator, DON (Director of Nurses), or designee.</p> <p>Record review revealed the facility admitted Resident #1 on 10/02/12 with diagnoses to include Sepsis secondary to Urinary Tract Infection, Possible Alzheimer's Dementia, and Anxiety.</p> <p>Review of the facility's investigation, dated</p>	F 225	<p>What measures have been put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Quality Assurance Coordinator provided education of the F 225 and N 108 laws along with the interpretive guidelines to the Administrator and the Director of Nurses on 8-15-14. The facility shall have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. This shall include a timely assessment of all non-interviewable residents who are cared for by an alleged perpetrator.</p>	

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F 225	<p>Continued From page 2</p> <p>7/14/14, revealed Resident #1 report that CMT #1 had hit him/her on the buttocks with a bedpan. Further review revealed there were three (3) non-interviewable residents skin assessments completed on 7/16/14 two days after the allegation of abuse.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/30/14 at 2:45 PM, revealed he completed three (3) skin assessments on non-interviewable residents.</p> <p>Interview with the Director of Nursing, on 07/30/14 at 1:30 PM and 3:55 PM, revealed there were no injuries found during the skin assessments completed on Resident #1's roommate and two (2) residents across the hall. She stated there were nine (9) non-interviewable residents on Resident #1's hall but staff did not complete skin assessments on all of them. She revealed the skin assessments were completed on three (3) resident's for the investigation because staff completed skin assessments weekly and the aides knew to report anything out of the normal and knew the investigation was going on. She stated she told staff to do the three (3) residents as part of her investigation to make sure residents were safe and she just randomly picked that number of residents.</p> <p>Interview with the Administrator, on 07/30/14 at 4:40 PM, revealed residents are looked at everyday in this facility.</p>	F 225	<p>How will this facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Administrator shall monitor the performance of the Director of Nurses weekly to ensure that all alleged violations and all substantiated incidents are reported according to the policy and procedure of the facility. This monitoring will be documented along with the Safety Team report to the Quality Assurance Team weekly for one year. Alleged compliance date is August 19, 2014</p>	