

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2014
NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
(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#22214 was conducted on 09/24/14 through 09/25/14 to determine the facility's compliance with Federal requirements. KY#22214 was substantiated with deficiencies cited with the highest scope and severity of "D".	F 000	The Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in this 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	F 225		



10/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator (X8) DATE: 10/17/14

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>to the administrator or his designated 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 initial report and facility policy and procedures, it was determined the facility failed to ensure an allegation of abuse was thoroughly investigated for two (2) of three (3) sampled residents (Resident #1 and Resident #2). On 08/17/14 Certified Nurse Aide (CNA) #2 observed CNA #1 handling Resident #1 in a rough manner. Additionally, CNA #2 observed CNA #1 telling Resident #2 to "shut up" repeatedly. The facility was notified of CNA #1's actions by CNA #3. The facility failed to have documented evidence they assessed residents that were not interviewable during the investigation following the allegation.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Facility Specific Protocol for Reporting of Suspected Resident Abuse/Neglect", dated 10/16/12, revealed employees are to ensure that all residents are protected from abuse, neglect and exploitation. Any alleged actions involving abuse, neglect or exploitation must be reported immediately to your supervisor or the Administrator. The supervisor or Administrator will take an immediate action to ensure the resident's safety and to prevent further potential</p>	F 225	<p>F225</p> <ol style="list-style-type: none"> Resident #1 and Resident #2 were interviewed on 08/17/2014 by the floor nurse about this incident with neither resident having any recollection of the events. Neither of these residents had any issues with staff or the way staff had treated them. Additionally, both residents were assessed by a RN, Resident #1 on 08/17/2014 and Resident #2 on 08/18/2014 to insure there were no signs of bruising or other injury. The Director of Nursing interviewed other residents, with no concerns being identified on 08/17/2014. The Director of Nursing also reviewed the skin assessments on 09/25/14 of residents under the care of C.N.A. #1 with no findings of bruises or injuries of unknown origin. The Director of Nursing will complete before 10/24/2014 a review of all skin assessments, and all incident reports, for a week before, during the week, and the week after the incident to insure there are no bruises or injuries of unknown origin. On 10/17/2014, the Administrator reviewed all abuse allegations for past 6 months to ensure any previous allegations were reported timely and investigated appropriately. The Corporate Nurse Consultant on 10/10/2014 educated the Director of Nursing on the investigation process and how to pick a sample of residents for review. Abuse retraining occurred on 08/17/2014 and was completed by a RN, the MDS Coordinator, with an emphasis on the process for reporting and the timing of any report. The entire staff will be retrained by 10/24/2014 and no employee will be allowed to work after that date until they have completed the abuse retraining. All newly hired employees are educated on our abuse policy during new employee orientation. 		

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F 225	Continued From page 2 abuse while a thorough investigation is completed. Review of a facility Initial Report provided to the Survey Agency, dated 08/17/14, revealed it was reported by CNA #3 that CNA #2 had approached him/her with concerns of actions from CNA #1. The concerns included CNA #1 had jerked Resident #1's arm while getting him/her up then flipped him/her off with her middle finger, then told Resident #2 to "shut up" multiple times. Record review revealed the facility admitted Resident #1 on 06/09/11 with diagnoses which included Encephalopathy Transcerebral Ischemia, Alzheimer's and Deaf. Review of the admission Minimum Data Assessment (MDS) assessment, dated 12/02/13, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of eleven (11) indicating the resident was interviewable. The resident was dependent on staff for extensive assistance with all activities of daily living and required two staff assist for transfers. Record review revealed the facility admitted Resident #2 on 10/20/13 with diagnoses which included Organic Brain Syndrome and Severe Senile Dementia. Review of the annual MDS assessment, dated 10/20/13, revealed the facility assessed Resident #2's cognition as severely impaired. The resident was dependent on staff for extensive assistance with all activities of daily living. Interview with CNA #2, on 09/24/14 at 10:05 AM revealed she and CNA #1 were working as a team on 08/17/14 to assist residents to get up for	F 225	F225 (cont.) 4. The CQI committee will review all allegations of abuse for timely notification and staff response and make recommendations to the Administrator for appropriate retraining. The training and reviews completed by the Director of Nursing will be reported to the CQI committee. The CQI committee will meet at least quarterly, including the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, and Maintenance, the CQI committee will meet and review the above no less than quarterly for one year. 5. Completion Date: 10/24/2014		
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F 225	Continued From page 3 breakfast. CNA #2 stated she observed CNA #1 to grab Resident #1 by the right arm and "jerk" him/her up from a lying position to a sitting position on the side of the bed. The CNAs both assisted Resident #1 to transfer to the bedside commode. CNA #1 was then observed to gesture her middle finger at the resident. CNA #2 revealed she felt the resident did not see the gesture as CNA #1 made the gesture to the resident's side and out of his/her line of vision. CNA #2 stated they then went to Resident #2's room to provide assistance to get up from the bed and ready for breakfast. She revealed Resident #2 was yelling out, which was a common everyday behavior for the resident and CNA #1 repeatedly yelled "shut up" to the resident. CNA #2 revealed after finishing care for Resident #2, CNA #1 and CNA #2 finished getting up their other assigned residents. CNA #2 stated there was a total of about ten (10) residents they assisted up on the morning of 08/17/14. She revealed the incidents observed with Resident #1 and Resident #2 had occurred about halfway through the morning routine which started shortly after the shift started at 7:00 AM. CNA #2 stated she did not immediately report what she had observed, but instead spoke with CNA #3 who was working another area of the facility. She stated CNA #3 told her to inform the nurse of what she had observed. CNA #2 revealed she was apprehensive to report CNA #1's actions as they were friends outside of the workplace. She additionally stated she was apprehensive to report to the nurse and planned to tell the Director of Nursing who was not present in the facility at the time and CNA #3 actually reported the incidents to the nurse. Additional interview with CNA #2 revealed CNA #1 left shortly after CNA #3 had reported to the nurse and has not been back	F 225			

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F 225	<p>Continued From page 4</p> <p>to the facility. She stated she was asked to write a statement of her observations and an inservice was given that afternoon about abuse/neglect and reporting all forms of abuse to the nurse immediately and not to stop and talk about it with other co-workers.</p> <p>Interview with CNA #3, on 09/24/14 at 11:00 AM, revealed on 08/17/14 she reported what CNA #2 told her to Registered Nurse (RN) #1. She stated CNA #2 told her that CNA #1 had stated she was going to report CNA #1 for being "mean.". CNA #1 had thrown a walker, kicking a wheelchair and was rough with Resident #1. CNA #1 had pointed a finger in Resident #2's face and said "Shut the F*** up". CNA #3 additionally stated she had an encounter with CNA #1 previously when passing ice at the start of the shift (7:00 AM) and she had told the nurse CNA #1 had been hateful to her.</p> <p>Interview conducted with RN #1, on 09/24/14 at 1:30 PM, revealed CNA #3 had reported CNA #1 was seen being rough with a resident and she was going to get with the the DON on the appropriate procedure. RN #1 stated an unsampled resident began having seizure activity about the same time as she was going to contact the DON so she took CNA #1 with her to that resident's room so the CNA would be in view until she could contact the DON. CNA #1 was with her when she talked with the DON via phone. RN #1 stated the DON instructed her to send CNA #1 home. She revealed RN #1 told CNA #1 there was an allegation she had been rough with a resident and CNA #1 denied it and left the facility (time clock punch indicated CNA #1 clocked out at 9:15 AM on 08/17/14). RN #1 stated she assessed Resident #1 and determined no injury had occurred and attempted to talk with Resident</p>	F 225			

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F 225	Continued From page 5 #2 but he/she was unable to communicate any understanding. She revealed she did not assess Resident #2. Interview with the Director of Nursing (DON), on 09/24/14 at 2:30 PM, revealed RN #1 notified her by phone on 08/17/14 in the morning of the allegations of CNA #1 jerking Resident #1 by the arm and giving the "bird" and told Resident #2 multiple times to shut up. The DON stated an inservice on abuse/neglect was implemented that day that stressed the immediacy of reporting suspected abuse/neglect. Twenty eight (28) interviewable residents were interviewed related to abuse/neglect with none reported. Interview with the Administrator and DON, on 09/24/14 at 3:10 PM, revealed non interviewable residents were not assessed on 08/17/14 for any signs or symptoms of abuse/neglect and felt any unexplained bruising or other potential symptoms of abuse/neglect would have been identified on the weekly skin assessments and talked about in the morning meetings.	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.	F 226			
	This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy and facility investigation it was				10/24/14

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F 226	Continued From page 6 determined the facility failed to ensure the abuse/neglect policy was implemented for two (2) of three (3) sampled residents (Resident #1 and Resident #2). On 08/17/14 Certified Nurse Aide (CNA) #2 observed CNA #1 to "jerk" Resident #1 by the arm from a lying position to a sitting position and do an inappropriate hand gesture directed at the resident. Additionally, CNA #1 was observed to tell another resident (#2) to "shut up" repeatedly. The actions of CNA #1 were not immediately reported as per the facility policy. A third CNA (#3) informed the nurse after having a conversation with CNA #2. The findings include: Review of the facility's policy titled Facility Specific Protocol for Reporting of Suspected Resident Abuse/Neglect, dated 10/16/12, revealed employees are to ensure that all residents are protected from abuse, neglect and exploitation. Any alleged actions involving abuse, neglect or exploitation must be reported immediately to your supervisor or the Administrator. An Initial Report provided to the Survey Agency, dated 08/17/14, revealed the issue reported to have occurred 08/17/14 at 7:30 AM and was not reported to the Director of Nursing (DON) until 9:47 AM. Review of the time card read out on 08/17/14 revealed CNA #1 clocked in at 7:00 AM and clocked out at 9:15 AM. Record review revealed the facility admitted Resident #1 on 06/09/11 with diagnoses which included Encephalopathy Transcerebral Ischemia, Alzheimer's and Deaf. Record review revealed the facility admitted	F 226	1:226 1. Resident #1 and Resident #2 were interviewed on 08/17/2014 by the floor nurse about this incident with neither resident having any recollection of the events. Neither of these residents had any issues with staff or the way staff had treated them. Additionally, both residents were assessed by a RN, Resident #1 on 08/17/2014 and Resident #2 on 08/18/2014 to insure there were no signs of bruising or other injury. 2. The Director of Nursing interviewed other residents, with no concerns being identified on 08/17/2014. The Director of Nursing also reviewed the skin assessments on 09/25/14 of residents under the care of C.N.A. #1 with no findings of bruises or injuries of unknown origin. The Director of Nursing will complete before 10/24/2014 a review of all skin assessments, and all incident reports, for a week before, during the week, and the week after the incident to insure there are no bruises or injuries of unknown origin. On 10/17/2014, the Administrator reviewed all abuse allegations for past 6 months to ensure any previous allegations were reported timely and investigated appropriately. 3. The Corporate Nurse Consultant on 10/10/2014 educated the Director of Nursing on the investigation process and how to pick a sample of residents for review. Abuse retraining occurred on 08/17/2014 and was completed by a RN, the MDS Coordinator, with an emphasis on the process for reporting and the timing of any report. The entire staff will be retrained by 10/24/2014 and no employee will be allowed to work after that date until they have completed the abuse retraining. All newly hired employees are educated on our abuse policy during new employee orientation.	

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F 226	<p>Continued From page 7</p> <p>Resident #2 on 10/20/13 with diagnoses which included Organic Brain Syndrome and Severe Senile Dementia.</p> <p>On 09/24/14 at 10:05, an interview was conducted with CNA #2 which revealed she and CNA #1 were working as a team getting residents up for the day. She observed CNA #1 to grab Resident #1 by the right arm and "jerk" him/her up from a lying position to a sitting position on the side of the bed. CNA #2 stated CNA #1 was then observed to gesture her middle finger at the resident. CNA #2 felt the resident did not see the gesture made by CNA #1 as the gesture was made to the resident's side and not in the resident's direct line of vision. CNA #2 further revealed they then went to Resident #2's room to assist him/her up for the day and the resident was yelling out as this was his/her usual behavior. CNA #2 stated CNA #1 yelled "shut up" to the resident multiple times. CNA #2 stated after finishing care for Resident #2, the CNAs finished assisting the remaining residents on their assignment up for the day. CNA #2 revealed she did not report the actions of CNA #1 to the nurse but told another CNA (#3) what she had observed. CNA #3 informed the nurse of what CNA #2 had told her.</p> <p>Interview with CNA #3 was conducted on 09/24/14 at 11:00 AM. CNA #3 revealed on 08/17/14 she reported what CNA #2 told her to Registered Nurse (RN) #1. She stated CNA #2 told her that she was going to report CNA #1 for being "mean." She stated CNA #2 stated CNA #1 had thrown a walker, kicking a wheelchair and was rough with Resident #1 and had pointed a finger in Resident #2's face and said "Shut the F*** up". CNA #3 additionally stated she had an</p>	F 226	<p><i>F 226 (cont.)</i></p> <p>4. The CQI committee will review all allegations of abuse for timely notification and staff response and make recommendations to the Administrator for appropriate retraining. The training and reviews completed by the Director of Nursing will be reported to the CQI committee. The CQI committee will meet at least quarterly, including the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, and Maintenance, the CQI committee will meet and review the above no less than quarterly for one year.</p> <p>5. Completion Date: 10/24/2014</p>		
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F 226	<p>Continued From page 8</p> <p>encounter with CNA #1 previously when passing ice at the start of the shift (7:00 AM) and she had told the nurse CNA #1 had been hateful to her.</p> <p>Interview conducted with RN #1, on 09/24/14 at 1:30 PM, revealed CNA #3 had reported CNA #1 was seen by CNA #2 being rough with a resident. She stated she summoned CNA #1 and was going to get with the the DON on the appropriate procedure. An unsampled resident began having seizure activity about the same time as she was going to contact the DON so she took CNA #1 with her to that resident's room so the CNA would be in view until she could contact the DON. CNA #1 was with her when she talked with the DON via phone. The DON instructed to send CNA #1 home. RN #1 told CNA #1 there was an allegation she had been rough with a resident and CNA #1 denied it and left the facility (time clock punch indicated CNA #1 clocked out at 9:15 AM on 08/17/14). RN #1 stated she assessed Resident #1 and determined no injury had occurred and interviewed him/her with the use of a communication board as the resident was deaf and he/she denied anyone had been mean or pulled on his/her arm. She attempted to talk with Resident #2 but he/she was unable to communicate any understanding. She did not assess Resident #2.</p> <p>Interview with the DON, on 09/24/14 at 2:30 PM, revealed RN #1 notified her by phone on 08/17/14 in the morning of the allegations of jerking Resident #1 by th arm and giving the "bird" and told Resident #2 multiple times to shut up. The DON stated an inservice on abuse/neglect was implemented that day that stressed the immediacy of reporting suspected abuse/neglect. Twenty eight (28) interviewable residents were</p>	F 226			

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F 226	Continued From page 9 interviewed related to abuse/neglect with none reported.	F 226			