

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

PRINTED: 11/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/13/2013
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342		
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00020918 was initiated and concluded on 11/13/13. KY#00020918 was substantiated with deficiencies cited.	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 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 laws.		
F 225 SS=E	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	Resident #1 and Resident #3 were interviewed by ADON and no psychosocial concerns were identified related to incidents. SRNA #3 and LPN #2 are no longer employed at the facility. All 14 residents that were interview able based on a BIMs scores between 13 and 15 were interviewed to identify if any other instances of abuse had not been reported. This was completed by Unit coordinators, ADON and DON on 11/15/13. Residents were reminded of their right to be free from abuse or neglect during those interviews.	12-28-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Rodina Atkins RN DON TITLE *DON* [X6] DATE *12-16-2013*

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 interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure alleged incidents of abuse were investigated and reported immediately to the appropriate State Agencies for two (2) of three (3) sampled residents (Resident #1 and #2). The facility failed to report and investigate allegations of verbal abuse for Resident #1 and Resident #2.</p> <p>The findings include: Review of the facility's policy, titled "Abuse Prohibition", undated, revealed verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or within their hearing distance, regardless of their age, ability to comprehend, or disability. Additionally, the policy specified witnessed verbal abuse incidents were reportable incidents that were to be investigated. Continued review of the policy revealed any incident of abuse or suspected abuse was to be reported immediately to the available charge staff person. According to the policy, the charge person was to immediately notify the Director of Nursing (DON) and Administrator. Further review revealed any individual suspected of causing abuse was to be removed from direct patient care until an investigation was completed.</p>	F 225	<p>F225 continued</p> <p>24 hour reports and any incident reports that involved injuries, bruises or possible indications of abuse were reviewed for investigation of abuse for residents that are not interview able. This was completed for the past 30 days by QA nurse and DON on 12/16/2013. A 25% sample of Employees was interviewed by ADON, DON and MDS nurse on 11/14/2013 through 12/16/13 to identify if they had witnessed any abuse of a resident that was not reported. The policy and procedure on abuse and neglect includes the definitions and the investigating and reporting process. Facility staff were re-educated on the policy on Abuse and Neglect by the ADON, DON and QA nurse and included the definitions of the types of abuse. Education was done on 11/14/2013, 11/15/2013 and 11/18/2013.</p>	

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F 225	Continued From page 2 Review of the facility's policy titled, "Standards of Conduct", dated February 2008, revealed examples of conduct and behavior considered inappropriate and unacceptable included any acts of disrespect, abuse, neglect and/or misconduct towards residents. Further review revealed failure to immediately report cases of actual or suspected abuse/neglect, any known violations of the law or state regulations, occurrences of actual or suspected harassment or discrimination, or any incident of a reportable nature to supervision or other members of management was inappropriate and unacceptable behavior and conduct. 1. Record review revealed the facility admitted Resident #1 on 09/13/13, with diagnoses which included Bipolar, Depression, Anxiety, Dementia, and Alzheimer's with Behavioral Disturbances. Review of the Admission Minimum Data Set (MDS), dated 09/20/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14), indicating the resident was cognitively intact and interviewable. Review of an Employee Verbal/Coaching form, dated 10/16/13 and acknowledged by the employee, State Registered Nursing Assistant (SRNA) #3 on 10/17/13, revealed she had been given a verbal coaching for unacceptable or inappropriate actions which included being "short" with residents and complaining loudly where residents could hear, about the care provided to residents. Interview with SRNA #3 on 11/13/13 at 3:01 PM, revealed she recalled an incident where she	F 225	F225 continued Supervisors (Nurses, Managers, and Dept. Heads) were also re-educated on the process by ADON on 11/14/2013. Investigating any reports of suspected abuse and reporting to the Administrator or Director of Nursing. The education on the abuse policy and procedure and will be completed every six months for 1 year. The abuse policy and procedure for investigating and reporting will also be reviewed during general orientation with all new employees. This will be the responsibility of the staff development coordinator. Daily observations of staff and resident interactions will be made by the DON, ADON, or supervising nurse to ensure staff language is appropriate when caring for residents. The DON, and ADON have initiated a QA plan to ensure continued compliance. The results of the interviews with		

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F 225	Continued From page 3 made an inappropriate comment after Resident #1 had requested assistance to go to the bathroom. SRNA #3 stated she did not make the comment to the resident. She indicated she made the comment to herself while walking toward the resident's room. Interview with Resident #1 on 11/13/13 at 2:30 PM, revealed a staff person had made "belittling" and "derogatory" comments when he/she requested assistance to the bathroom. Resident #1 indicated he/she did not remember the name of the staff person he/she overheard. Resident #1 indicated he/she did remember the date and stated "it made me feel just as small as I could feel". Resident #1 stated he/she felt "it was unprofessional" of the staff person to have behaved in this manner. Interview with the Director of Nursing (DON) on 11/13/13 at 2:39 PM, revealed at the time of the incident involving SRNA #3 she did not investigate the incident as a suspected verbal abuse because she did not find the comment to be abusive to the resident. Further interview revealed she found the comment to be wrong and inappropriate. She stated she was new to her position as DON, and in hind sight, according to the facility's definition of verbal abuse, the incident was possibly verbally abuse to a resident and should have been investigated as such. 2. Record review revealed the facility admitted Resident #2 on 01/12/12 and readmitted the resident on 09/19/13, with diagnoses which included Anxiety, Metastatic Lung Cancer and Chronic Obstructive Pulmonary Disease Exacerbation. Review of the Significant Change MDS, dated 06/17/13, revealed the facility	F 225	F225 continued residents, and staff and the results of the incident and 24 hour report review will be reported to QA by the Director of Nursing at the January QA meeting. Interviews of at least 5 interview able residents will be completed by the DON or ADON each month for the next 6 months to ensure no further incidents of staff using inappropriate language, using abusive language or belittling the residents have occurred and the results will also be reported to QA each quarter.		

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F 225	<p>Continued From page 4</p> <p>assessed Resident #2 to have a Brief Interview for Mental Status score of fifteen (15), which indicated the resident was cognitively intact and interviewable.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 11/13/13 at 5:53 AM, revealed she did not remember the specific date; however, recalled Resident #2 was having difficulty breathing. LPN #1 indicated she left Resident #2's room to obtain medications and overheard LPN #2 in Resident #2's room. She stated she did not know what LPN #2 said to Resident #2; however, Resident #2 requested LPN #2 not come back into his/her room. LPN #1 stated she did not report the incident because she did not witness what was said. Continued interview with LPN #1 on 11/13/13 at 7:14 AM, revealed a SRNA had reported to her that LPN #2 yelled at and was hateful to Resident #2. She stated she questioned LPN #2 and LPN #2 told her she did not yell and was not hateful to Resident #2. LPN #1 stated she did not report the incident nor did she complete an incident report form, per the facility policy, because LPN #2 denied yelling and being hateful to the resident.</p> <p>Interview with SRNA #1 on 11/13/13 at 6:04 AM, revealed she did not remember the specific date; however, recalled Resident #2 was having difficulty breathing and LPN #1 left the resident's room. SRNA #1 stated LPN #2 was very loud and hateful to Resident #2 after LPN #1 left the room. Further interview revealed SRNA #1 did report this incident to LPN #1.</p> <p>Interview with SRNA #2 on 11/13/13 at 6:20 AM, revealed she had witnessed abuse at this facility before. SRNA #2 stated she recalled an incident</p>	F 225		

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F 225	Continued From page 5 on an unknown date, where Resident #2 was having difficulty breathing and LPN #2 was "rude, very rude" to Resident #2. SRNA #2 stated she reported this to LPN #1. Interview with Resident #2 on 11/13/13 at 5:35 AM, revealed some staff are nicer than other staff. Resident #2 stated some of the staff are "mouthy and rude" at times. Interview with LPN #2, on 11/13/13 at 7:01 AM, revealed she did not remember this incident. She indicated she denied raising her voice or being hateful and/or rude to any residents, including Resident #2. Interview with the DON on 11/13/13 at 10:07 AM, revealed the incident involving LPN #2 was not reported nor was an incident report completed, per the facility's policy. She stated her expectations would be for this incident to have been reported, an incident report completed and an investigation initiated as per the facility's policy to ensure resident safety. The DON stated the facility's policy and procedure was an alleged abuse incident was to be reported to the nurse on duty who would begin an investigation. She stated the nurse would notify administration of the allegation immediately to ensure resident safety.	F 225			
F 226 SS=E	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	F226 The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	12-28-13	

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F 226	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure policy and procedures were implemented related to abuse for two (2) of three (3) sampled residents (Resident #1 and #2). The facility failed to identify verbal abuse and implement facility policy for reports of alleged verbal abuse. Resident #1 overheard a State Registered Nursing Assistant (SRNA) make derogatory comments when the resident requested assistance to the bathroom. Additionally, staff reported hearing Licensed Practical Nurse (LPN) #2 yell at and treat Resident #2 rudely.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse Prohibition" undated, revealed verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or within their hearing distance, regardless of their age, ability to comprehend, or disability. Additionally, the policy indicated witnessed verbal abuse incidents were reportable incidents that were to be investigated. Review of the policy revealed any incident of abuse or suspected abuse was to be reported immediately to the available charge staff person. The policy revealed the charge person was to immediately notify the Director of Nursing (DON) and Administrator. Further review revealed any individual suspected of causing abuse was to be removed from direct patient care until an investigation was completed.</p>	F 226	<p>F226 cont Resident #1 and Resident #3 were interviewed by ADON and no psychosocial concerns were identified related to incidents. SRNA #3 and LPN #2 are no longer employed at the facility.</p> <p>All 14 other residents that were interview able based on a BIMs scores between 13 and 15 were interviewed by Unit coordinators, ADON and DON to identify if any other instances of abuse had not been reported and to ensure the procedure for investigation had been followed per facility policy. The 24 hour reports and any incident reports that involved injuries, bruises or possible indications of abuse were reviewed by QA nurse and DON on 12/16/2013 for investigation of abuse for residents that are not interview able. This was completed for the past 30 days. A random 25% sample of employees was interviewed by DON, ADON and MDS nurse on 11/15/2013 through 12/16/2013 to identify if they had witnessed any abuse toward a resident that was not reported.</p>	

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F 226	<p>Continued From page 8</p> <p>bathroom. She stated she was making the comment to herself while walking to the resident's room, not to the resident.</p> <p>Interview with the Director of Nursing (DON) on 11/13/13 at 2:39 PM, revealed at the time of the incident, involving Resident #1, she had not investigated as she did not find SRNA #3's comment abusive to the resident. She indicated she found SRNA #3's comment to be wrong and inappropriate. The DON stated she was new to her position; however, per the facility's definition of verbal abuse, should have investigated the incident as per facility policy.</p> <p>2. Record review revealed Resident #2 was admitted by the facility on 01/12/12 and readmitted on 09/19/13, with diagnoses which included Anxiety, Metastatic Lung Cancer and Chronic Obstructive Pulmonary Disease Exacerbation. Review of the facility's Significant Change Minimum Data Set (MDS) dated 06/17/13, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact and interviewable.</p> <p>Interview with Resident #2 on 11/13/13 at 5:35 AM, revealed some staff were "mouthy and rude".</p> <p>Interview with SRNA #1 on 11/13/13 at 6:04 AM, revealed an incident occurred which involved Resident #2. She stated she could not recall the specific date; however, one day when Resident #2 was having difficulty breathing, she saw LPN #1 leave the resident's room. She stated LPN #2, after LPN #1 left the room, was very loud and hateful to Resident #2. SRNA #1 stated she did report this incident to LPN #1 as per facility policy.</p>	F 226	<p>F226 continued</p> <p>The Administrator, DON or ADON will review all grievances and reports of suspected or witnessed abuse by staff, and residents. They will report their findings of those reviews to the QA committee quarterly for 1 year.</p>	

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F 226	Continued From page 9 Interview with SRNA #2 on 11/13/13 at 6:20 AM, revealed she had witnessed abuse at this facility. She indicated an abusive incident occurred; however, she was unable to recall the date. SRNA #2 stated LPN #2 had been "rude, very rude" to Resident #2 one day when the resident was having difficulty breathing. SRNA #2 stated she reported this information to LPN #1 as per facility policy. Interview with LPN #1 on 11/13/13 at 5:53 AM, revealed she could not recall the specific date; however, it was on a day when Resident #2 was having difficulty breathing and she had the resident's room to obtain medications. She stated she overheard LPN #2 in Resident #2's room; but, didn't know what LPN #2 had said to the resident. LPN #1 indicated Resident #2 requested LPN #2 not come back into his/her room. LPN #1 stated she did not report this incident because she did not witness it. In an additional interview with LPN #1 on 11/13/13 at 7:14 AM, she stated a SRNA had reported to her that LPN #2 yelled at and was hateful to Resident #2. She stated she questioned LPN #2 about this incident and, LPN #2 reported she did not yell at Resident #2 and had not been hateful to this resident. LPN #1 stated she did not report the incident nor did she complete an incident report form, as per the facility policy, because LPN #2 denied the alleged incident. Interview with LPN #2 on 11/13/13 at 7:01 AM, revealed she did not remember this incident occurring. She indicated she denied raising her voice or being hateful and/or rude to any residents including Resident #2.	F 226			

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F 226	Continued From page 10 Interview with the DON on 11/13/13 at 10:07 AM, revealed the incident was not reported nor was an incident report completed as per facility policy. She indicated her expectations were for this allegation to have been reported and an incident report completed. The DON stated an investigation should have been initiated, per the facility's policy, to ensure resident safety. She stated the facility's policy and procedure was when an allegation of abuse was received it should be reported to the nurse on duty who would begin an investigation and, notify administration of the allegation immediately to ensure resident safety.	F 226			