

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185279 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/13/2015 |
| NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066 | |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 223 SS=D | <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, abuse investigation, and Plan of Action, it was determined the facility failed to protect one (1) of three (3) sampled residents (Resident #1) from abuse by a staff member. Resident #1 sustained two (2) skin tears to the right hand after Certified Nurse Aide (CNA) #1 grabbed the resident's hands to stop him/her from hitting at her during care. Resident #1 refused care and CNA #1 told the resident she would provide care to him/her and if he/she told her no, she would call the police.</p> <p>The findings include:</p> | F 223 | Past noncompliance: no plan of correction required. | |

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

TITLE

(X6) DATE

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 223 | Continued From page 1 Review of the facility's policy and procedure, titled "Alleged Abuse/Potential Neglect/Exploitation Reporting/Investigation, last revised 07/26/12, revealed it was the policy of this facility to provide an environment that promoted dignity and respect for residents and one that prohibited abuse and/or neglect. Review of the facility's policy titled, "Resident Rights-Federal and Kentucky", not dated, revealed the resident had the right to be free from verbal, sexual, physical or mental abuse. The facility should not use verbal, mental or physical abuse nor employee individuals who had been convicted for abusing, neglecting or mistreating residents. The resident had the right to choose activities, interact with members of the community and make choices about his or her life in the facility that were significant to the resident. Record review revealed the facility admitted Resident #1 on 12/22/14 with diagnoses which included Late Effects of Cerebral Vascular Accident, Type II Diabetes Mellitus, Seizure Disorder, Depression, Anxiety, Peripheral Neuropathy, and Chronic Pain. Review of a Significant Change Minimum Data Set (MDS) assessment, dated 04/22/15, revealed the facility assessed the resident's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of five (5), indicating the resident was not interviewable. Review of the facility's investigation, dated 04/15/15, revealed an allegation of abuse was made by Resident #1 on 04/15/15 at 8:30 AM against CNA #1. The alleged abuse was reported to the Assistant Director of Nursing (ADON) at | F 223 | | | |

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| F 223 | <p>Continued From page 2</p> <p>8:30 AM on 04/15/15 by CNA #1. Resident #1 accused CNA #1 of being verbally and physically abusive to him/her. Further review of the investigation revealed while CNA #1 was caring for Resident #1, the resident refused care and was told by CNA #1 that she was going to provide care to him/her and he/she was not going to tell her no. When CNA #1 began to attempt to provide care, Resident #1 hit at her and CNA #1 grabbed the resident's hands and told him/her she was going to call the police on her if he/she did not allow care to be provided. When CNA #1 grabbed Resident #1's hands, two (2) skin tears were obtained to the resident's right hand. Further review revealed the facility substantiated the abuse allegation and CNA #1 was immediately removed from the resident care area and placed on suspension and later terminated after the completion of the investigation.</p> <p>Interview with CNA #1, on 05/12/15 at 9:03 AM, revealed while she was attempting to provide care to Resident #1 on 04/15/15, the resident began to resist care and started to hit at her. CNA #1 stated she grabbed Resident #1's hands, held them, and told him/her she was going to provide care to him/her and he/she was not going to tell her no. CNA #1 revealed after she let go of Resident #1's hands, the resident began to hit at her again and she grabbed the resident's hands again, this time causing two (2) skin tears to Resident #1's right hand. CNA #1 stated she left Resident #1's room and met a nurse in the hallway and told her what had occurred. She revealed she then went to the nursing station and reported the incident to the ADON immediately. She stated she felt she had not done anything wrong because she followed the facility policy on reporting immediately which was what she</p> | F 223 | | | |

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| F 223 | <p>Continued From page 3</p> <p>learned in orientation. CNA #1 stated she was not allowed to return to the floor to work and was suspended pending an investigation. She stated she was later called in and terminated.</p> <p>Interview with CNA #2, on 05/12/15 at 3:48 PM, revealed she had not worked with CNA #1 until 04/15/15, the day of the incident, and she had not heard anything negative about her. CNA #2 stated she and CNA #1 was on the hall and two (2) call lights were going off and she went to answer one (1) of them and CNA #1 went into Resident #1's room. CNA #2 revealed when she went in to help CNA #1, she witnessed CNA #1 talking badly to the resident, grabbing the resident's hands, and telling the resident he/she could not refuse to be changed because if he/she did she would call the cops on him/her. CNA #2 stated she intervened and asked CNA #1 to leave the room and go to the nursing station to report the incident to the ADON. CNA #2 revealed CNA #1 reported the incident to the ADON and was escorted to the ADON's office by the Medical Records Clerk to write a statement and remained there until the Administrator and Director of Nursing (DON) could speak with her. Further interview revealed she had been re-educated on abuse and neglect on 04/15/15 by the Director of Nursing (DON) and the Administrator.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/13/15 at 10:05 AM, revealed she was in the hallway when CNA #1 came out of Resident #1's room and she appeared to be mad because she stated Resident #1 had been rude to her. LPN #2 stated CNA #1 was walking to the nursing station stating she needed to fill out an event report. LPN #2 revealed she entered Resident #1's room and he/she was upset over the incident because CNA</p> | F 223 | | | |

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| F 223 | <p>Continued From page 4</p> <p>#1 had demanded she let her check him/her. Further interview revealed she had been re-educated on abuse and neglect on 04/15/15 by the DON and the Administrator.</p> <p>Interview with LPN #1, on 05/13/15 at 9:30 AM, revealed CNA #1 came to the desk and stated she needed to fill out an event report. LPN #1 stated when she asked what had happened, CNA #1 explained she was attempting to check on Resident #1 when the resident began to swing at her. LPN #1 revealed CNA #1 said she took a hold of the resident's hands and told the resident she was going to check him/her and the resident was not going to tell her "no" and if he/she did, she was going to call the police on the resident. LPN #1 further revealed CNA #1 stated Resident #1 continued to swing at her, so she grabbed the resident's hands which caused two (2) skin tears to the resident's right hand. LPN #1 revealed she asked the Medical Records Clerk to escort CNA #1 to the ADON's office and stay with her until the Administrator and DON could come to speak with her. LPN #1 stated CNA #1 did not return to the floor to work and was suspended and later terminated. Further interview revealed she had been re-educated on abuse and neglect on 04/15/15 by the DON and the Administrator.</p> <p>Interview with the ADON, on 05/13/15 at 7:47 AM, revealed as part of her job duties, she checked on resident's appointments each day and then would go to each hallway to see what staff may be available to accompany the resident to the appointment. The ADON stated on 4/15/15, she witnessed CNA #1 come out of Resident #1's room and CNA #1 stated Resident #1 had two (2) skin tears to his/her hand. The ADON revealed the Medical Records Clerk was sitting behind the</p> | F 223 | | | |

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| F 223 | <p>Continued From page 5</p> <p>nursing station and she asked her and CNA #1 to go to her office while she went to get the Administrator and the DON. The ADON stated CNA #1 had orientation and was educated on abuse and there had not been any other issues with her related to resident interactions. Additional interview revealed she had been re-educated on abuse and neglect on 04/15/15 by the DON and the Administrator.</p> <p>Interview with the Medical Records Clerk, on 05/12/15 at 3:39 PM, revealed she was asked by the ADON to sit with CNA #1 so she would not be unattended at the facility after the incident with Resident #1 occurred. She revealed she stayed with CNA #1 until the DON and Administrator relieved her and CNA #1 had not been back to work since the incident. Further interview revealed she had been re-educated on abuse and neglect on 04/15/15 by the DON and the Administrator.</p> <p>Review of Social Services Notes, dated 04/15/15 at 10:30 AM, revealed she spoke with Resident #1 regarding the incident and the resident informed her she did not want "that girl" around him/ her again. Later in the afternoon on 04/15/15 at 3:30 PM, she visited the resident again and the resident revealed he/she felt safe at the facility and no one had ever tried to hurt him/ her before.</p> <p>Interview with Social Services Director, on 05/13/15 at 12:10 PM, revealed after the incident occurred on 04/15/15 between Resident #1 and CNA #1, she was called out of the morning meeting to speak with Resident #1 about the incident. The Social Services Director stated the resident was upset and was not feeling well to</p> | F 223 | | | |

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| F 223 | <p>Continued From page 6</p> <p>begin with because of an upper respiratory infection. The Social Service Director stated the resident did not normally exhibit any behaviors but did not want to be messed with this day. The Social Service Director further revealed the next day she spoke with the resident and the resident expressed to her she was glad that girl (CNA #1) was gone and would not be coming back to work. Additional interview revealed she had been re-educated on abuse and neglect on 04/15/15 by the DON and the Administrator.</p> <p>Review of Nursing Notes, dated 4/15/15 at 9:00 AM and 04/16/15 at 10:00 AM, revealed Resident #1 had two (2) small skin tears to his/her right hand and the family and physician were notified of the incident.</p> <p>Interview with the DON, on 05/13/15 at 9:21 AM, revealed when she spoke with CNA #1 and she felt the CNA did not have a clue what she had done would be considered abuse because the CNA felt like she followed facility procedure by reporting it right away. Further interview with the DON, revealed she and the Administrator substantiated the complaint of abuse made by Resident #1 and the situation was dealt with appropriately. CNA #1 was removed from the resident care area immediately, Resident #1 was assessed immediately, interviews were conducted with residents with a BIMS score of seven (7) or greater, skin assessments were completed on 100% of residents, and CNA #1 was not allowed to return to work and was terminated. (Administrator out of the building at conference)</p> <p>The State Survey Agency verified the following actions were taken to correct the deficiency:</p> | F 223 | | | |

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| F 223 | Continued From page 7 Review of the Plan of Action and follow-up record conducted by the facility, dated 04/15/15, revealed an emergent Quality Assurance meeting was held and addressed Resident Rights, Abuse policy, and the facility's action plan. Staff involved in the allegation was placed on administrative leave immediately pending investigation. Immediate 100% inservice was begun by the DON, Assistant DON, Unit Managers, and a night shift nurse supervisor, reviewing the abuse policy and Resident Rights with a post test afterwards. Resident #1 was observed over the next three (3) days to ensure emotional and psychosocial needs were being met; then weekly x two (2) weeks, then quarterly x two (2) quarters. 100% of residents had skin audits completed beginning 04/15/15 and completed on 04/17/15 by licensed nursing with observation focusing on skin tears and other issues with no new concerns were identified. Interviews were conducted on 04/15/15 by a Licensed Practical Nurse (LPN) and the Social Services Director (SSD) with 100% of interviewable residents with a BIMS score of seven (7) or greater using a resident interview questionnaire related to abuse/neglect with no new concerns identified. Review of an emergent Quality Assurance meeting minutes, held on 04/15/15, revealed the meeting was held to discuss a caretaker allegation of abuse. Follow-up from the meeting revealed the issue had been resolved with the termination of CNA #1. Review of Nursing Notes and Social Services Notes, dated 04/15/15 through 04/18/15, revealed the resident was monitored for signs and symptoms of psychosocial or emotional upset | F 223 | | | |

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| F 223 | <p>Continued From page 8 with no new issues identified.</p> <p>Review of the revised care plan, dated 04/15/15 revealed the physician's order for the treatment of the skin tears. Review of the revised care plan, dated 05/06/15, revealed Resident #1 refused incontinent care at times, but not daily. Further review revealed the resident was at risk for injury related to becoming physical after the initiation of care and at risk for impaired skin integrity with refusal of incontinent care at times.</p> <p>Review of interviews, conducted by facility staff, with residents with a BIMS score of seven (7) or greater, using a tool titled, "Resident Interview Questions Abuse/Neglect", dated 04/15/15, revealed no new issues with abuse or neglect.</p> <p>Interviews on 05/12/15 with unsampled residents: Resident A at 8:25 AM, Resident B at 8:30 AM, Resident C at 8:35 AM, Resident D at 8:40 AM, Resident E at 8:45 AM, Resident F at 8:50 AM, Resident G at 8:55 AM, Resident H at 9:00 AM, Resident I at 9:05 AM, Resident J at 9:10 AM, Resident K at 9:15 AM, Resident L at 9:20 AM, Resident M at 9:25 AM, Resident N at 9:30 AM, and Resident O at 9:34 AM, with a BIMS score of seven (7) or greater, revealed no complaints of abuse and/or neglect.</p> <p>Review of skin assessments, dated 04/15/15 through 04/16/15, revealed 100% of residents skin assessments were completed by licensed nurses with any new issues identified followed up on immediately.</p> <p>Review of event interview statements, dated 04/15/15, revealed 100% of staff were interviewed related to the incident that allegedly</p> | F 223 | | | |

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| F 223 | Continued From page 9 occurred on 04/15/15 with no new issues identified. Review of inservice sign in logs, dated 04/15/15, revealed, an immediate 100% inservice was conducted by the DON, Assistant DON, Unit Managers, and a night shift nurse supervisor, reviewing the abuse policy and Resident Rights with a post test afterwards. Interviews conducted on 05/13/15 with CNA #3 at 10:00 AM, CNA #4 at 10:10 AM, CNA #5 at 10:20 AM, CNA #6 at 10:30 AM, and CNA #7 at 10:40 AM, the Maintenance Technician at 10:45 AM, the Dietary Manager at 10:50 AM, and the Activity Director a 11:00 AM, revealed they had been re-educated on abuse including the different types of abuse, who to report to and when, and how to protect the residents. | F 223 | | | |