

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2013
NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301		
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F 000	INITIAL COMMENTS An Abbreviated Survey Investigating KY20965 was conducted on 11/12/13-11/14/13 to determine the facility's compliance with Federal requirements. KY20965 was substantiated with A deficiency cited at a S/S of "D".	F 000	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility 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 critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.		
F 225 SS=D	483.13(c)(1)(I)-(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	1. Resident #1 was assessed by Director of Nursing and Assistant Director of Nursing on 11/4/13 with no negative outcomes. No other residents were affected by the alleged deficient practice. On 11/4/13 the incident that occurred on 10/6/13 was re-investigated with a new root cause determined. 2. All other resident's skin was assessed to ensure no other residents were affected by the alleged deficient practice. Resident's were interviewed regarding abuse and neglect including the care they receive from facility staff with no negative findings.		

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

[Signature]

TITLE

Administrator

(X5) DATE

12-6-13

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 facility policy and procedure review, it was determined the facility failed to interview all staff present at the time of the alleged occurrence of abuse and failed to report the allegation of abuse and injuries of unknown origin to the appropriate State agencies at the time of the incident for one (1) of three (3) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse; Neglect, and Misappropriation", last revised 03/2013 revealed under subtitle Policy: B. "All allegations of abuse involving abuse and injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines". Under subtitle Training/Identification/Prevention: G. Sign & Symptoms of abuse (bruises, injuries of unknown origin, crying, fearful, increased agitation, and withdrawal) to name a few. H. reporting of abuse and whom to report to. Under subtitle Protection of the Resident, The administrator and/or DON will notify state agencies according to their guidelines". Under the subtitle, Investigation: all allegations of abuse will be investigated and reported to the</p>	F 225	<p>3. Staff were in-serviced during the week of 11/04/13 by Staff Development Coordinator on facility abuse policy to include how to identify potential abuse and reporting information immediately to Director of Nursing and Administrator. Administrator, Director of Nursing and Human Resource Manager met with the staff that was involved in investigation on 11/8/13 to re-educate them on Abuse Policy and Protocols. Consultations were issued on failure to follow policy and to report immediately to Director of Nursing and Administrator. Director of Nursing completed re-education with Assistant Director of Nursing on conducting a thorough investigation for injuries of undetermined origin emphasizing interviewing and utilization of appropriate root cause analysis to identify causative factor for identified injury.</p>		

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F 225	<p>Continued From page 2</p> <p>appropriate agencies. The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances. The person(s) observing the incident will immediately report and provide a written statement that includes name of resident, date and time incident occurred, where it occurred, staff involved and a description of what occurred. Investigations are kept confidential. Under subtitle, Follow-up: all allegations are to be reported within the time frame allotted by state agency.</p> <p>Record review revealed Resident #1 was admitted to the facility on 02/23/09 with diagnoses to include Senile Delirium, Osteoporosis, Malaise and Fatigue, Difficulty in Walking, Anemia, and Cataracts. Review of the annual Minimum Data Set (MDS) assessment, dated 05/10/13, revealed the facility assessed Resident #1's cognition as severely impaired and he/she required extensive assistance with activities of daily living.</p> <p>Review of the facility's investigation, on 10/07/13 Resident #1 was noted to have a red nose, grabbed her by the collar and head butted her. The Assistant Director of Nursing (ADON) began an investigation of the redness. During the investigation, the ADON identified that the resident would rub her nose with geri-sleeves frequently which they believed could have been the cause of the injury. On 11/03/12, CNA #1 was a no call, no show, and the staff reported that CNA #1 may have pinched Resident 1's nose during the head butting situation on 10/06/13.</p> <p>Interview with CNA #1, on 11/13/13 at 10:00 AM, revealed Resident #1 head butted her on 10/06/13 and no one else was in the room. The</p>	F 225	<p>4. Nursing Administration team will review skin assessments weekly to ensure all altered skin integrity have been documented, investigated and root cause analysis identified. Nursing Administration team will report findings to Director of Nursing weekly for proper follow up. Director of Nursing will review skin assessment findings and issue educational referrals to Staff Development Coordinator for 1:1 education with nurses identified as needing "investigation and root cause analysis" educational needs. Director of Nursing will report findings monthly to Quality Assurance team for 3 months for recommendations and follow up. Social Services Director will conduct weekly rounding to interview residents regarding care and services and report findings to Administrator. Social Services Director will report findings monthly to Quality Assurance team for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 12/29/2013</p>	12/29/13	

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F 225	<p>Continued From page 3</p> <p>CNA stated she notified the charge nurse at that time of the resident's behavior. CNA #1 further stated the facility called her in on Tuesday, 11/05/13, and asked what had happened and had her write a statement about the incident concerning the head-butting.</p> <p>Interview with CNA #6, on 11/12/13 at 6:00 PM, revealed she had noticed Resident #1's nose was red and bruised on 10/07/13. The CNA reported it to Licensed Practical Nurse (LPN) #1. CNA #6 further revealed Resident #6 had stated someone had hit his/her nose.</p> <p>Interview with CNA #3, on 11/14/13 at 1:36 PM, revealed while providing care to Resident #1 on 10/07/13 she noted Resident #1 had a red bruised area to the tip of his/her nose.</p> <p>Interview with CNA #4, on 11/14/13 at 2:36 PM, revealed she worked on 10/07/13 and she had noticed Resident #1's nose was large and reddish with a blue tint on the tip of his/her nose. The CNA stated Resident #1 told her someone had pinched him/her while sitting at the lunch table. CNA #4 further stated Resident #1 had stated two girls came in his/her room and one of them pinched him/her. CNA #4 stated the charge nurse had walked by the table at the time, and she thought the Charge Nurse had overheard it. CNA #4 further stated Resident #1 told her again on 10/09/13 that someone had pinched his/her nose. CNA #4 stated she thought the incident would be investigated; but had not been questioned about the incident until 11/08/13 around 4:00 PM by the DON and she was not asked to write a statement concerning the matter. CNA #4 further stated she felt she had reported it to the nurse when the nurse walked by the table.</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>Interview with LPN #1, on 11/12/13 at 6:20 PM and on 11/14/13 at 3:20 PM revealed she observed Resident #1's nose and it was bruised and she could not determine how it had happened. The LPN stated at a later time the resident said something about being pinched by two boys. LPN #1 further revealed she had talked to the ADON about the reported pinching on the 11/04/13.</p> <p>Interviews with Registered Nurse (RN) #1, CNA #2, and CNA #7, on 11/14/13 at 3:02 PM and 2:59 PM and 11/13/13 at 10:33 AM respectively, revealed they were working the night of the incident related to Resident #1's nose but RN #1 was not asked to write a statement until 11/08/13. CNA #2 and CNA #7 were never asked about the incident.</p> <p>Interview with ADON, on 11/13/13 at 10:44 AM, revealed she was made aware of Resident #1's bruised nose on 10/07/13 during the morning meeting and could not determine through interview with the resident what had happened. The ADON further revealed she was not sure how it happened, and only talked with Licensed Practical Nurse (LPN) #1 and CNA #8 regarding the incident and did not investigate it any further. The ADON revealed she did not talk with anyone else because that was her investigation and she felt like the area came about by Resident #1 wiping his/her nose on sleeve. The ADON further revealed it was reported later Resident #1 had head butted one of the CNAs and she assumed now that was how the bruise occurred.</p> <p>Interview with the Director of Nursing (DON), on 11/12/13 at 3:30 PM, on 11/13/13 at 11:10 AM</p>	F 225			

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F 225	Continued From page 5 and on 11/14/13 at 1:14 PM respectively, revealed CNA #1 and CNA #2 did not work at the facility any longer and there had only been one allegation which was reported to the State on 11/08/13 in which it was alleged an employee pinched Resident #1's nose. The DON further revealed she was not made aware of the allegation until 11/03/13 but should have been made aware of the incident. The DON further stated there was no documentation concerning an assessment of Resident #1 at the time of the incident.	F 225			