

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

PRINTED: 11/07/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/24/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303
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F 000	INITIAL COMMENTS  An abbreviated survey (KY #20840) was conducted on 10/23/13 through 10/24/13 to determine the facility's compliance with Federal requirements. KY#20840 was substantiated with regulatory violations cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
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	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1. Corrective action for those found to have been affected?  Resident #1 was placed on supervised visits with the perpetrator on 10/5/13 and ongoing. Supervision is being provided by facility management staff.  2. Corrective action for those with the potential to be affected.  A review of all policies were done by nursing management to ensure they are being followed. Review also included reviewing process utilized on 3 other self reports in last six weeks, interviews of staff, residents and families to ensure they understand how to report any concerns and that facility is responding quickly and appropriately. A review of all employee files by the personnel clerk for those hired in the last four months was done to ensure appropriate screening of employees.	11/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Kau, E.D.</i>	TITLE	(X6) DATE 11/15/13
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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, facility investigation review and facility policy review, it was determined the facility failed to prevent further potential abuse while an abuse investigation was in progress for one (1) of three (3) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>A review of the facility policy titled "Responding to and Investigating an Abuse Allegation", dated 05/22/13, revealed an alleged abuse committed by an employee or visitor is covered under this procedure and the charge nurse should diffuse the situation and remove the aggressor from all patient contact.</p> <p>A record review revealed Resident #1 was admitted to the facility on 10/26/12 with diagnosis to include Altered Mental Status and Alzheimer's Disease.</p> <p>A review of the facility investigation, completed on 10/09/13 by the Administrator, revealed Resident #1's son was observed shoving a biscuit into the resident's mouth while in the lobby. The resident was then taken to the dining room accompanied by the son where he was observed verbally abusing the resident.</p>	F 225	<p>3. Systemic changes to ensure the deficient practice will not recur.</p> <p>All staff received education by nursing management on abuse policies POL:504-01, PRO 52002-01, PRO 51003 which include definitions of abuse, protection of the resident, process of reporting. Anyone not trained as of 11/16/13 will not be allowed to work until they receive the training. These same policies will be reviewed in general orientation.</p> <p>4. How will the facility will monitor performance to ensure the solutions are maintained.</p> <p>Abuse investigative protocol completed by staff development coordinator and PBC on 11/15/13. Results will be taken to the Performance Improvement committee (consisting of at least medical director, administrator, director of nursing services, social services) on 11/21/13. Any events that occur over the next three months will be reviewed fully by the PI Committee to ensure compliance.</p>		

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F 225	<p>Continued From page 2</p> <p>An interview with Certified Medication Aide (CMA) #1, on 10/24/13 at 8:42 AM, revealed she observed Resident #1's son sitting with the resident in the lobby and the son was shoving a biscuit into the resident's mouth and was overheard calling the resident "stupid". CMA #1 notified Licensed Practical Nurse (LPN) #1 of what she had seen. The resident was then taken by staff to the dining room, where the son followed. CMA #1 stated she sat at the same table and overheard the son verbally abuse the resident by saying, "I'll f*****g feed you like a baby", "I don't care if it is all over your f*****g face", "doesn't your brain f*****g work" and "you're going to f*****g eat your food". The CMA revealed the Nursing Supervisor and LPN #1 were in the dining room and observed what was going on but did not remove the son from the resident's contact.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 10/24/13 at 10:07 AM, revealed she saw Resident #1 in the dining room with his son at his side. The SRNA stated the son was trying to get his father to eat but his tone of voice wasn't nice. The SRNA did overhear the son call his father "stupid" using a harsh tone.</p> <p>An interview with LPN #1, on 10/24/13 at 10:30 AM, revealed she talked with Resident #1's son on the unit regarding his father and his intravenous therapy prior to the son going to the lobby where his father was. The LPN stated she was approached by CMA #1 who was looking for the Nursing Supervisor and the LPN made her aware of what Resident #1's son had done. LPN #1 stated she walked through the lobby to find the Nursing Supervisor and saw Resident #1's son</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>with a biscuit in his hand, shoving it into the resident's face like he was trying to force him to eat. The LPN stated she went to the break room to notify the Nursing Supervisor of the incident and she came to the lobby to observe what was going on. The LPN revealed the resident was then taken to the dining room by staff and the son accompanied them. LPN #1 revealed the resident's son knew he was being watched and got up and left on his own from the dining room and the facility. The LPN revealed at no time did the staff remove the son from the resident's contact.</p> <p>An interview with the Nursing Supervisor, on 10/24/13 at 9:18 AM, revealed CMA #1 reported to her Resident #1's son was seen shoving a biscuit into the residents mouth while sitting in the lobby. The Nursing Supervisor stated she had the resident and his son in her sight after she was notified but she did not attempt to separate the resident and his son after the reported physical abuse. The Nursing Supervisor revealed after the resident was taken to the dining room she sat in a chair in the dining room to monitor what was going on. She could tell the son was talking to his father but she was unable to hear what was being said. She did hear the son tell his father, "see that lady over there..... she is watching me". The son then left the facility. The nursing supervisor revealed at no time did staff remove the son from the resident's contact.</p> <p>An interview with the Director of Nursing (DON), on 10/24/13 at 11:11 AM, revealed at no time was the son left alone out of staff's sight after the incident with the biscuit was observed in the lobby.</p>	F 225			

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F 226 F 226 SS=D	Continued From page 4 483.13(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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility investigation review and facility policy review, it was determined the facility failed to follow the facility'sd policy and procedure related to removing the aggressor from resident contact for one (1) of three (3) sampled residents (Resident #1).  The findings include:  A review of the facility policy titled "Responding to and Investigating an Abuse Allegation", dated 05/22/13, revealed an alleged abuse committed by an employee or visitor is covered under this procedure and the charge nurse should diffuse the situation and remove the aggressor from all patient contact.  A record review revealed Resident #1 was admitted to the facility on 10/26/12 with diagnosis to include Altered Mental Status and Alzheimer's Disease.  A review of the facility investigation, completed on 10/09/13 by the Administrator, revealed Resident #1's son was observed shoving a biscuit into the resident's mouth while in the lobby. The resident	F 226 F 226	F226  1. Corrective action for those found to have been affected?  Resident #1 was placed on supervised visits with the perpetrator on 10/5/13 and ongoing. Supervision is being provided by facility management staff.  2. Corrective action for those with the potential to be affected.  A review of all policies were done by nursing management to ensure they are being followed. Review also included reviewing process utilized on 3 other self reports in last six weeks, interviews of staff, residents and families to ensure they understand how to report any concerns and that facility is responding quickly and appropriately. A review of all employee files by the personnel clerk for those hired in the last four months was done to ensure appropriate screening of employees.  3. Systemic changes to ensure the deficient practice will not recur.  All staff received education by nursing management on abuse policies POL:504-01, PRO 52002-01, PRO 51003 which include definitions of abuse, protection of the resident, process of reporting. Anyone not trained as of	11/16/13	

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F 226	<p>Continued From page 5</p> <p>was then taken to the dining room accompanied by the son where he was observed verbally abusing the resident.</p> <p>An interview with Certified Medication Aide (CMA) #1, on 10/24/13 at 8:42 AM, revealed she observed Resident #1's son sitting with the resident in the lobby and the son was shoving a biscuit into the resident's mouth and was overheard calling the resident "stupid". CMA #1 notified Licensed Practical Nurse (LPN) #1 of what she had seen. The resident was then taken by staff to the dining room, where the son followed. CMA #1 stated she sat at the same table and overheard the son verbally abuse the resident by saying, "I'll f*****g feed you like a baby", "I don't care if it is all over your f*****g face", "doesn't your brain f*****g work" and "you're going to f*****g eat your food". The CMA revealed the Nursing Supervisor and LPN #1 were in the dining room and observed what was going on but did not remove the son from the resident's contact.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 10/24/13 at 10:07 AM, revealed she saw Resident #1 in the dining room with his son at his side. The SRNA stated the son was trying to get his father to eat but his tone of voice wasn't nice. The SRNA did overhear the son call his father "stupid" using a harsh tone.</p> <p>An interview with LPN #1, on 10/24/13 at 10:30 AM, revealed she talked with Resident #1's son on the unit regarding his father and his intravenous therapy prior to the son going to the lobby where his father was. The LPN stated she was approached by CMA #1 who was looking for the Nursing Supervisor and the LPN made her</p>	F 226	<p>11/16/13 will not be allowed to work until they receive the training. These same policies will be reviewed in general orientation.</p> <p>4. How will the facility will monitor performance to ensure the solutions are maintained.</p> <p>Abuse investigative protocol completed by staff development coordinator and PBC on 11/15/13. Results will be taken to the Performance Improvement committee (consisting of at least medical director, administrator, director of nursing services, social services) on 11/21/13. Any events that occur over the next three months will be reviewed fully by the PI Committee to ensure compliance.</p>		

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F 226	<p>Continued From page 6</p> <p>aware of what Resident #1's son had done. LPN #1 stated she walked through the lobby to find the Nursing Supervisor and saw Resident #1's son with a biscuit in his hand, shoving it into the resident's face like he was trying to force him to eat. The LPN stated she went to the break room to notify the Nursing Supervisor of the incident and she came to the lobby to observe what was going on. The LPN revealed the resident was then taken to the dining room by staff and the son accompanied them. LPN #1 revealed the resident's son knew he was being watched and got up and left on his own from the dining room and the facility. The LPN revealed at no time did the staff remove the son from the resident's contact as per the facility's policy.</p> <p>An interview with the Nursing Supervisor, on 10/24/13 at 9:18 AM, revealed CMA #1 reported to her Resident #1's son was seen shoving a biscuit into the residents mouth while sitting in the lobby. The Nursing Supervisor stated she had the resident and his son in her sight after she was notified but she did not attempt to separate the resident and his son after the reported physical abuse. The Nursing Supervisor revealed after the resident was taken to the dining room she sat in a chair in the dining room to monitor what was going on. She could tell the son was talking to his father but she was unable to hear what was being said. She did hear the son tell his father, "see that lady over there..... she is watching me". The son then left the facility. The nursing supervisor revealed at no time did staff remove the son from the resident's contact as per the facility's policy.</p> <p>An interview with the Director of Nursing (DON), on 10/24/13 at 11:11 AM, revealed at no time was</p>	F 226			

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