

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

PRINTED: 03/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/28/2014
NAME OF PROVIDER OR SUPPLIER  HIGHLANDSPRING OF FT THOMAS			STREET ADDRESS, CITY, STATE, ZIP CODE 960 HIGHLAND AVENUE FORT THOMAS, KY 41075		
(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#00021361, was initiated on 02/26/14 and concluded on 02/28/14. KY#00021361 was unsubstantiated with deficient practice cited.	F 000	HIGHLANDSPRING OF FORT THOMAS  SURVEY ENDED February 28, 2014  PLAN OF CORRECTION		
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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation report and policy, it was determined the facility failed to report an allegation of abuse and the investigation results as per the policy for one (1) of three (3) sampled residents (#1). Resident #1 was allegedly restrained by two (2) aides to the bed with a bath blanket on 12/21/13.  The findings include:  A review of the facility's policy titled, "Abuse/Neglect/Misappropriation of Property", revised September 2011, revealed it was the policy of the facility to prevent abuse including mistreatment, neglect, or the misappropriation of resident property, and to report incidents to the Administrator and to other officials in accordance with State law through established procedures. Continued review revealed the results of all investigations were to be reported to the	F 226	Without admitting or denying the validity or existence of the alleged deficiencies, Highlandspring of Fort Thomas provides the following plan of correction. The law requires us to prepare a plan of correction for the citation regardless of whether we agree with it. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Highlandspring of Fort Thomas reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.  THIS PLAN OF CORRECTION SERVES AS HIGHLANDSPRINGS OF FORT THOMAS CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF March 30 <sup>th</sup> 2014.  RECEIVED MAR 25 2014 F226  The accurate and speedy identification of any event, which would place our residents at risk, is a primary concern of Highlandspring of Fort Thomas. An abbreviated survey was initiated on 2/26/14 and concluded on 2/28/14. KY#00021361 was unsubstantiated with a deficient practice cite of F226. Although the facility was not found to have a substantiated Abuse allegation, it was found the facility allegedly did not report the incident in accordance to state law.  Highlands has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and the misappropriation of resident property. Accurate and timely reporting of incidents both alleged and substantiated will be sent immediately to the state agency per facility policy.		

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

*[Handwritten Signature]*

TITLE

*[Handwritten Title]*

(X6) DATE

*[Handwritten 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 226	<p>Continued From page 1</p> <p>Administrator or designated representative and to other officials in accordance with State law to include the State Agencies within five (5) working days of the incident. Review of the policy revealed it indicated the Administrator or designee had the responsibility to thoroughly investigate the alleged incident; and complete the investigation within five (5) working days of the incident. Further review revealed a copy of the report was to be sent to the State Survey Agency.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 12/19/13, with diagnoses which included Left Hip Fracture, Osteoarthritis and Parkinson's Disease. A review of the Admission Minimum Data Set (MDS) assessment dated 12/26/13, revealed the facility assessed Resident #1 to have a Brief interview for Mental Status (BIMS) score of nine (9) which indicated the resident was moderately impaired in cognition.</p> <p>Review of the facility's investigation documentation dated 12/21/13, revealed Certified Nursing Assistant (CNA) #1 had entered Resident #1's room on 12/21/13, and observed a bath blanket around the resident which had been tucked under the mattress on the right side of the bed. CNA #1 reported this to Licensed Practical Nurse (LPN) #1. Continued review of the investigation revealed LPN # 1, asked LPN #2 to assess the resident with her. According to the investigation documentation, LPN #1 and LPN #2 observed a bath blanket around the resident's waist and hips and tucked under the right side of the mattress. Further review of the investigation documentation revealed LPN #1 reported the incident to the House Supervisor, Assistant Director of Nursing (ADON) and the Director of</p>	F 226	<p>Resident # 1 currently resides at the facility without further incident/restraint concerns.</p> <p>Resident complaints and investigations since January 1<sup>st</sup>, 2014 will be reviewed by March 21<sup>st</sup> 2014 by the Director of Nursing and Administrator to assure that each are reported to the state agency per facility policy if indicated. All were in compliance.</p> <p>The Administrator and DON provided additional education for the Highlandspring Department Heads on March 20<sup>th</sup> 2014 on the Abuse, Neglect and Misappropriation policy with a focus on the importance of immediate notification to appropriate agencies of any allegation of resident abuse. The Director of Nursing provided additional education for the nursing staff on March 28<sup>th</sup>, 2014 on the Abuse, Neglect and Misappropriation policy with a focus on the importance of immediate notification to appropriate agencies of any allegation of resident abuse.</p> <p>A PI worksheet to review reporting of complaints /allegations will be completed by the DON or designee weekly for the next (4) weeks, twice monthly for a month, then monthly to assure compliance. If issues are noted, the DON or designee takes appropriate action at the time the concern is noted. The PI worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need for continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit A.</p> <p>The Director of Nursing will monitor compliance in the above mentioned summary for FTAG 226. Compliance Date March 30<sup>th</sup>, 2014</p>		

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F 226	<p>Continued From page 2</p> <p>Nursing (DON) immediately. Additionally, review of the investigation documentation revealed the facility had initiated an investigation of the incident on 12/21/13; and the facility's investigation concluded the bath blanket had not been a restraint as it had not restricted Resident #1's movement of arms and legs. Further review revealed no documented evidence the incident had been reported to State Agencies.</p> <p>Interview with Resident #1 on 02/28/14 at 11:35 AM, revealed the resident did not remember the incident.</p> <p>Interview with LPN #2 on 02/28/14 at 2:00 PM, revealed she had been the 11:00 PM to 7:00 AM nurse, beginning her shift at 11:00 PM on 12/20/13 and ending her shift the morning of 02/21/13. She stated she had been assigned to Resident #1's care during her shift. LPN #2 stated the resident had been "very restless and agitated" all night; and she had called the Physician to get "something" for him/her. She indicated she had received an order for Ativan (a medication used to treat anxiety) which she administered. She further stated she had given Resident #1 a Heparin (a medication used to treat blood clots) injection subcutaneously (sub-q) in his/her abdomen at about 6:45 AM on 12/21/13; and had not seen "anything at that time".</p> <p>Interview with LPN #1 on 02/28/14 at 2:50 PM, revealed CNA #1 had reported the incident to her on 12/21/13 at approximately 7:30 AM; and had asked who the 11:00 PM to 7:00 AM nurse had been. She stated she had asked LPN #2, the 11:00 PM to 7:00 AM nurse, to go with her to Resident #1's room. According to LPN #1 they found Resident #1 with a blanket wrapped around</p>	F 226	

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F 226	Continued From page 3 his/her waist and hips and the blanket tucked under the mattress on the right side of the bed. LPN #1 stated this was not facility procedure; and indicated LPN #2 had not known why the blanket was on that way. LPN #1 stated she reported the incident immediately to the night shift supervisor, Unit Manager and ADON. She stated she had completed the Incident Report and given it to the DON.  Interview with CNA #2 on 02/28/14 at 1:50 PM, revealed she had cared for Resident #1 on 12/21/13. She stated Resident #1 had been very "confused" during the night; had pulled off his/her brief; tried to pull out his/her staples; and "took off two (2) bandages. According to CNA #2 she and CNA #3 had put a bath blanket around the resident's hips to keep him/her from pulling the staples out. CNA #2 stated the nurse had given Resident #1 a shot of Ativan which had not "phased" him/her; and she had been "okay" with the bath blanket. She further stated the bath blanket had not restrained the resident "at all". CNA #2 stated she would "never tie a resident down".  Interview with CNA #3 on 02/28/14 at 1:55 PM, revealed she had cared for Resident #1 on 12/21/13. She stated the resident had staples down his/her left hip. CNA #3 stated Resident #1 had been "very wild" that night; and had been "picking" at the staples. She stated she put the blanket under the resident's left hip, up over the resident and around to the right side of the bed. According to CNA #3, the blanket had not been tucked in. She stated the blanket had not restrained Resident #2 in "any way"; she had placed it to protect the resident.	F 226			

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F 226	<p>Continued From page 4</p> <p>Interview with the ADON on 02/28/14 at 3:05 PM, revealed the investigation had been initiated immediately when the nurse reported the incident. She indicated every staff person who had entered Resident #1's room that night had been interviewed about the incident. The ADON stated with the results of the investigation the facility had not felt the blanket had been a restraint. She stated she had done phone interviews with staff; however had not been involved in the decision making of whether to report or not report the incident to State Agencies.</p> <p>Interview with the Chief Operating Officer (COO) on 02/28/13 at 3:40 PM, revealed he had been in the facility the morning of 12/21/13, and had been involved in investigating the incident. He stated video was observed and staff interviewed; and the facility had determined the bath blanket had not been a restraint; therefore there had been "nothing to report" to State Agencies.</p>	F 226		

**Resident Rights  
PI Worksheet**

AREA OF REVIEW Abuse Reporting      DATE: \_\_\_\_\_  
 DEPARTMENT Nursing  
 EVALUATOR: \_\_\_\_\_  
 OTHER: F 226

NAME OR IDENTIFYING INFORMATION	1	2	3	4	5	6	7	8	9	10	% COMP
Staff interviewed knows how to report suspected incidents/abuse/theft											
IF AN INCIDENT REPORTED											
Reported timely to supervisor											
Reported timely to OIG											

**Comments:**

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