

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

PRINTED: 10/24/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/10/2013
NAME OF PROVIDER OR SUPPLIER  HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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	F 000	Corrective action for both residents # 1 and # 2 was immediate job suspension and resulting termination for respective perpetrators. Additionally, since resident # 1 has a BIMS score of less than 8, a skin assessment was completed by a licensed nurse on 9/27/13 in order to evaluate for unknown injuries. None were detected by this assessment. Resident # 2 has a BIMS score of 15, is interviewable, and self reported the allegation. He did not report any physical abuse. Other residents with the potential to be affected: all residents the perpetrators were assigned to for care with a BIMS score of less than 8 were physically assessed for injuries by a licensed nurse between the dates of 9/27/13 and 10/4/13; none were detected. All residents the perpetrators were assigned to for care with a BIMS score greater than or equal to 8 were interviewed by the Administrator and the Administrative Assistant from 10/1/13 to 10/11/13 questioning whether or not the residents had any allegations of abusive actions by staff; none were detected. Systemic changes put into place on 10/28/13 were to update the Abuse Policy to include skin assessments on all patients in-house with BIMS scores of less than 8 and interviews for patients with BIMS scores greater than or equal to 8. These assessments and interviews are to be conducted immediately at the onset of an investigation. To monitor for performance, an impromptu meeting of the internal Quality Assurance team will be convened immediately by the Administrator in order to ensure the policies and procedure for an abuse investigation have been completed.	10/28/13	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Janet H. Campbell, Administrator* TITLE: \_\_\_\_\_ (X6) DATE: 10/29/13

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, review of the facility's investigation, and review of the facility's policy and procedure, the facility failed to thoroughly investigate allegations of abuse of two (2) of three (3) sampled residents (Resident #1 and #2). On 09/27/13, Resident #1 informed the Social Worker that someone had been "mean" to her and upon reviewing a facility video it revealed Certified Nursing Assistant (CNA #1) forcefully pushed Resident #1's wheelchair, releasing the chair and Resident #1 went approximately 30 feet before being caught by another staff member. In addition, Resident #2 reported on 10/01/13 while being placed on the toilet, CNA #4 told the resident that he/she could not go to the bathroom for another two hours because he/she went to the bathroom too much. Review of the facility investigations revealed the facility failed to interview other interviewable residents and/or conduct skin assessments on non-interviewable residents to determine if there was any other evidence of abuse.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure on Abuse, dated 09/03/08, revealed if any type of abuse is reported, a full investigation of the allegation will be conducted by the Administrator.</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>1. Record review revealed the facility admitted Resident #1 on 06/23/08 with diagnoses to include Alzheimer's Disease, Hypertension, Depressive Disorder, and history of falls.</p> <p>A review of the facility's investigation revealed on 09/27/13, Resident #1 informed the Social Worker that someone had been "mean" to her and upon reviewing a facility video the facility determined Certified Nursing Assistant (CNA #1) forcefully pushed Resident #1's wheelchair, releasing the chair and Resident #1 went approximately 30 feet before being caught by another staff member.</p> <p>Further review of the investigation revealed there was no evidence the facility interviewed other interviewable residents and/or conducted skin assessments on non-interviewable residents to determine if there was any other evidence of abuse.</p> <p>2. Record review revealed the facility admitted Resident #2 on 08/24/09 with diagnoses to include Cerebral Palsy, Hypertonicity of the Bladder, Depressive Disorder, Anxiety, Contracture of the Joints, Constipation, and Nocturia.</p> <p>A review of the facility's investigation revealed on 10/01/13, Resident #2 reported while being placed on the toilet, CNA #4 told the resident that he/she could not go to the bathroom for another two hours because he/she went to the bathroom too much.</p> <p>Further review of the investigation revealed there was no evidence the facility interviewed other</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>interviewable residents and/or conducted skin assessments on non-interviewable residents to determine if there was any other evidence of abuse.</p> <p>An interview with the Social Services Director (SSD), on 10/09/13 at 2:36 PM, revealed she was not aware if any interviews were conducted with other residents after both incidents or not, but she personally did not do any interviews.</p> <p>An interview with Director of Nursing (DON), on 10/10/13 at 11:52 AM, revealed although Resident #1 had a skin assessment completed after the incident, other non-interviewable residents were not assessed and after the incident with Resident #2, other residents were not interviewed to ensure that someone else had not been abused.</p> <p>An interview with the Administrator, on 10/10/13 at 11:30 AM, revealed Resident #1 was assessed after the incident and Resident #2 was asked if he/she was hurt in any way and he/she told the Administrator "no". The Administrator stated she did not think they interviewed any other residents after the incidents.</p>	F 225			