

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

PRINTED: 12/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185154</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME OF THE INNOCENTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 EAST MARKET STREET LOUISVILLE, KY 40206</b>	
(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	<b>INITIAL COMMENTS</b>  An Abbreviated Survey was initiated on 12/10/14 and concluded on 12/11/14 to investigate complaint KY 22569. The Division of Health Care unsubstantiated the allegation with related deficiencies cited.	F 000	"This Plan of Correction is prepared and submitted pursuant to Federal and State law. This Plan of Correction does not constitute an admission of, or agreement to, any alleged deficiencies or to any statement, findings, facts, or conclusions that form the basis of the alleged deficiencies. This facility reserves the right to challenge the alleged deficiencies and any statements, findings, facts, or conclusions that form the basis of the alleged deficiencies in any legal proceeding".	1/23/2015
F 224 SS=D	<b>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</b>  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 observations, interviews and record review, it was determined the facility staff failed to implement their policy on reporting allegations of abuse immediately for one (1) of four (4) sampled residents, Resident #1. A License Practical Nurse witnessed physical and verbal abuse and delayed notification of a supervisor for fifteen (15) to twenty (20) minutes and allowed the perpetrator to continue to provide care to other residents on the unit. In addition, a Housekeeper witnessed the same physical and verbal abuse and failed to report the incident to a supervisor.  The findings include:  Review of the facility's Abuse Policy, revised February 2013, revealed physical abuse was defined as shaking or pushing a resident. Verbal	F 224	F Tag 224 PROHIBIT MISTREATMENT / NEGLECT/ MISAPPROPRIATION  The statement of deficiency indicated a staff member witnessed physical and verbal abuse of Resident #1 and delayed reporting the incident for a period of fifteen (15) to twenty (20) minutes and a second staff member witnessed the same alleged abuse and failed to report the incident to a supervisor thus allowing the perpetrator to continue to provide care to other residents on the unit.  Individual Re-Training sessions were held by the DON with Nurse #1 on December 18, 2014 and with Housekeeper #1 on December 18, 2014 to re-educate these individuals on identification of abuse and / or neglect, immediately protecting residents from individuals that are suspected to have abused or otherwise mistreated residents,	

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

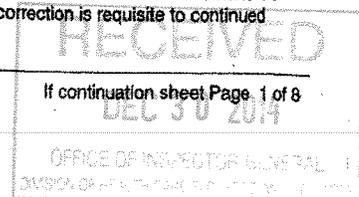
TITLE

*X Adm...*

(X6) DATE

*X 12-30-14*

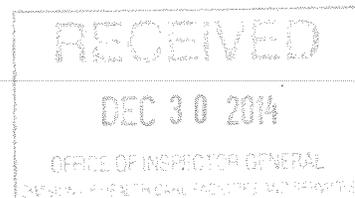
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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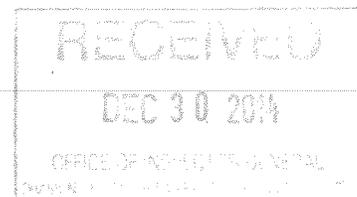
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F 224	<p>Continued From page 1</p> <p>abuse was defined as shouting or using threatening language. The policy clearly stated any incident of suspected abuse was to be reported immediately.</p> <p>Review of the facility's Managing Allegations of Abuse Policy, revised August 2007, revealed an allegation of abuse was to be reported immediately.</p> <p>Review of the facility's Residents/Clients Rights Policy revised November 2007, revealed staff of the facility were to report allegations of abuse immediately.</p> <p>Review of the Unusual Occurrence form, dated 12/03/14, revealed at approximately 9:30 AM, Respiratory Therapist #3 was doing all of Resident #1's care and during the course of the care, the resident managed to de-cannulate himself/herself four times. His/her heart rate was good, his/her sats remained at 93-96%. The resident was angry, agitated and mad. She may have told the resident a little loudly to please stop and they would be done real fast. At the time the nurse came in to help her, after the trach care, the resident quieted down and was ok. During suctioning she noticed a scratch on the left side of the resident's neck. She may or may not have scratched the resident. Written by RT #3. The form was signed by the Director of Nursing on 12/03/14.</p> <p>Review of the Director of Nursing's interview with Licensed Practical Nurse (LPN) #1, dated 12/03/14, revealed the housekeeper motioned for him to come to Resident #1's room. The LPN paused briefly outside the resident's room and witnessed RT #3 apparently agitated and</p>	F 224	<p>the importance of immediately reporting concerns about resident treatment and to identify the individuals to whom reports shall be made. This Corrective Action shall protect Resident #1 and other residents from having the potential to be affected by the same alleged deficient practice identified in the statement of deficiency. (SEE ATTACHMENT A)</p> <p>Systemic changes made to ensure that the deficient practice will not recur include broad staff refocus and retraining on abuse prohibition practices. A retraining package titled "Focus on Abuse and Neglect Prohibition Practices" was developed by the DON and the VPCS on December 18, 2014. This retraining package was distributed to all staff on December 19, 2014 with an expected signature return date of January 19, 2015. (SEE ATTACHMENT B)</p> <p>In an effort to ensure the above solutions are sustained into the future, the Medical Social Services Coordinators, shall include the "Focus on Abuse and Neglect Prohibition Practices" in each new employee orientation, in Annual Skills Validations of current employees and during Annual Mandatory Resident Rights Training. The Administrator, the DON and the VPCS will each conduct 5 spontaneous interviews of staff randomly selected each quarter of 2015, to ensure continued understanding of these practices. A report detailing the findings</p>		



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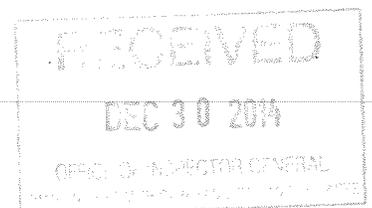
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F 224	<p>Continued From page 2</p> <p>speaking loudly to the resident, 'slamming' the resident's head back onto the headrest of the wheelchair. The LPN immediately entered the room and asked if there was something wrong and did she need help. The RT replied she was having problems with the resident, that the resident had been fighting her the entire time she had been suctioning the trach. The LPN observed a scratch on the resident's neck above the trach collar. After RT #3 left the room, the LPN picked up and held the resident to comfort him/her. The LPN then returned the resident to the wheelchair. There was no other injuries noted.</p> <p>Review of the Director of Nursing's interview with Housekeeper #1, dated 12/03/14, revealed she had been doing her daily mopping and noticed the RT was becoming agitated with Resident #1. She was treating him a little rough, moving his head around. Housekeeper #1 stated the resident was beet red. The housekeeper stated she heard the RT say she was getting tired of this and you're not being a good baby today. The housekeeper got the attention of the LPN so he could help.</p> <p>Review of the Director of Nursing's interview with RT #3, dated 12/03/14, revealed the resident was fine during treatment until she started suctioning him/her. The resident became fussy and fighting her during suctioning. The resident de-cannulated himself/herself four times and she was having difficulty getting his trach back in and his trach collar on to hold it in place. RT #3 stated she thought LPN #1 came in to help her because he heard her telling the resident to hold still, probably rather loudly.</p> <p>Review of the Summary of Findings written by the DON, not dated, revealed the alleged abuse</p>	F 224	<p>of the spontaneous interviews shall be submitted to the Risk Management Committee and likewise to the Quality Improvement Committee quarterly in February, May, August and November 2015. (SEE ATTACHMENT C)</p> <p>All unusual occurrences, reports and Summaries of Findings submitted to the OIG for suspected abuse and neglect shall be reviewed by the Administrator to determine if timely reporting took place. Persons found to have not taken immediate action to protect residents, to remove the suspected perpetrator from all resident care, and to have immediately reported suspected abuse and neglect shall have individual retraining by the Staff Development Coordinator.</p>		



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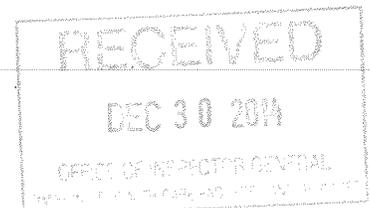
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F 224	<p>Continued From page 3</p> <p>incident was reported to her by the LPN, on 12/03/14 at approximately 11:15 AM and it occurred at 9:30 AM. The summary further indicated RT #3 admitted to speaking loudly to the resident and to holding down the resident's arms. The summary stated the resident was unable to communicate wants and needs and could not protect himself/herself from injury.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/12/13 with diagnoses of DiGeorge Syndrome, Tracheostomy, Gastric Tube, and other Lung Diseases. Review of his/her shift assessment for 12/03/14 revealed there were no significant changes in his/her medical condition post alleged abuse incident.</p> <p>Observations of the cottage where Resident #1 lived, on 12/10/14 and 12/11/14, revealed the residents were in semi-private rooms. The residents in this cottage were mechanical ventilated residents. Staffing parameters were 5 Nurses, 2 RT's, and 1 Certified Nursing Assistant (CNA). The staff interacting with the residents on 12/10/14 had calm voices and the residents were non-verbal, but none of the residents displayed behaviors of fear from the staff. On 12/11/14 respiratory was observed providing care for Resident #1. There were no concerns with the care.</p> <p>Interview with the Director of Respiratory Therapy, on 12/10/14 at 1:15 PM, revealed the facility's respiratory staff was trained on Abuse during orientation and annually. RT #3 upon reporting of the allegation had been suspended pending the investigation.</p>	F 224			



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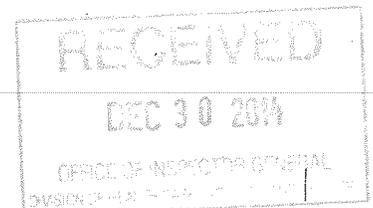
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F 224	<p>Continued From page 4</p> <p>Interview with Housekeeper #1, on 12/10/14 at 1:22 PM, revealed she had been cleaning in the room of Resident #1 when she heard RT #3 tell Resident #1 that she had had enough of his/her behaviors and then pushed the resident's head back. The housekeeper exited the room and saw LPN #1 coming out of the next resident's room. She motioned with her head that the LPN should enter Resident #1's room and then she left the area. She did not report what she witnessed to a supervisor. She stated she felt RT #3 was really angry with Resident #1.</p> <p>Interview the LPN #1, on 12/11/14 at 8:25 AM, revealed he was the staff member that the housekeeper had motioned to enter Resident #1's room. He stated as he entered the room from the doorway, he saw RT #3 shake Resident #1 and state she had had enough of him/her. At that point he stepped in and asked the RT if she needed help. Resident #1's trach needed ties and he assisted RT #3 to place the ties. After the ties were secure RT #3 went to the another resident's room, checked the residents ventilator and then left the room. After RT #3 left the room, LPN #1 cuddled Resident #1 for fifteen (15) to twenty (20) minutes to stop him/her from crying. Physical Therapy came and took Resident #1 to therapy and at that time the LPN left the room. He went to find the Clinical Supervisor and when he could not find her, he went to the Director of Nursing (DON) and reported the incident to her.</p> <p>Attempted interview with RT #3, on 12/11/14 at 2:10 PM and 2:30 PM, revealed no response to messages left as of 12/15/14.</p> <p>Interview with the DON, on 12/11/14 at 11:30 AM, revealed when RT #3 was interviewed, she stated</p>	F 224			



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F 224	Continued From page 5 Resident #1's trach had come out four (4) time and she had difficulty replacing the trach. RT #3 admitted she had raised her voice and while trying to replace the trach Resident #1 had been scratched on the neck and she had pushed his/her neck back to replace the trach. The DON stated when she interviewed the LPN, he felt RT #3 had been aggressive with Resident #1. She also stated the incident should have been reported immediately.  Interview with the Vice President of Clinical Services, on 12/11/14 at 2:15 PM, revealed the staff was educated to notify one of the four (4) Administrators for allegations of suspected abuse.  Interview with the Senior Vice president, on 12/11/14 at 2:30 PM, revealed any suspected incident of suspected abuse was to be reported immediately to management.	F 224		
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 interviews and record review, it was determined the facility failed to ensure staff followed their policy to report a suspected incident of alleged abuse immediately for one (1) of four (4) sampled residents, Resident #1. Licensed	F 226		



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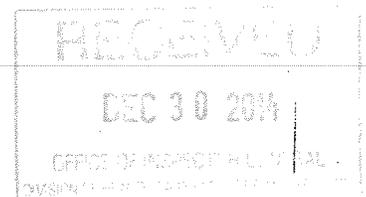
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F 226	Continued From page 6 Practical Nurse #1 and Housekeeper #1 failed to report immediately to a supervisor they had witnessed physical and verbal abuse by Respiratory Therapist #3.  The findings include:  Review of the facility's Abuse Policy, revised February 2013, revealed physical abuse was defined as shaking or pushing a resident. Verbal abuse was defined as shouting or using threatening language. The policy clearly stated any incident of suspected abuse was to be reported immediately.  Review of the facility's Managing Allegations of Abuse Policy, revised August 2007, revealed an allegation of abuse was to be reported immediately.  Review of the facility's Residents/Clients Rights Policy revised November 2007, revealed staff of the facility were to report allegations of abuse immediately.  Review of the facility's Child Abuse/Neglect Identification Policy revised February 2013, revealed allegations of abuse were to be reported immediately.  Review of the written statement from LPN #1, dated 12/03/14, revealed at approximately 10:00 AM on 12/03/14 he witnessed RT #3 shake Resident #1 and say to him/her, I have had enough of you. In response the LPN assisted RT #3 to secure the trach ties for Resident #1 and then he cuddled the resident until physical therapy took Resident #1 to therapy. At approximately 11:15 AM he reported the incident	F 226	"This Plan of Correction is prepared and submitted pursuant to Federal and State law. This Plan of Correction does not constitute an admission of, or agreement to, any alleged deficiencies or to any statement, findings, facts, or conclusions that form the basis of the alleged deficiencies. This facility reserves the right to challenge the alleged deficiencies and any statements, findings, facts, or conclusions that form the basis of the alleged deficiencies in any legal proceeding".  F Tag 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES  The statement of deficiency indicated two staff members witnessed physical and verbal abuse of Resident #1 and failed to report the incident immediately thus allowing the perpetrator to continue to provide care to other residents on the unit.  Individual Re-Training sessions were held by the DON with Nurse #1 on December 18, 2014 and with Housekeeper #1 on December 18, 2014 to re-educate these individuals on identification of abuse and / or neglect, immediately protecting residents from individuals that are suspected to have abused or otherwise mistreated residents, the importance of immediately reporting concerns about resident treatment and to identify the individuals to whom reports shall be made. This Corrective Action	1/23/2015

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DIVISION OF HEALTH CARE SERVICES

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F 226	<p>Continued From page 7 to the Director of Nursing (DON).</p> <p>Review of Summary of Findings written by the DON, dated 12/08/14, revealed LPN #1 did not report the allegation of abuse until 11:15 AM on 12/03/14 and Housekeeper #1 did not report it to any supervisor. The facility abuse policy stated the incident would be reported immediately.</p> <p>Interview with the Senior Vice President of the facility, on 12/11/14 at 2:30 PM, revealed the facility policy was not followed when LPN #1 did not report the alleged incident of abuse for Resident #1 immediately, allowing RT #3 to remain in the clinical area and provide care to other residents.</p>	F 226	<p>shall protect Resident #1 and other residents from having the potential to be affected by the same alleged deficient practice identified in the statement of deficiency. (SEE ATTACHMENT A)</p> <p>Systemic changes made to ensure that the deficient practice will not recur include broad staff refocus and retraining on abuse prohibition practices. A retraining package titled "Focus on Abuse and Neglect Prohibition Practices" was developed by the DON and the VPCS on December 18, 2014. This retraining package was distributed to all staff on December 19, 2014 with an expected signature return date of January 19, 2015. (SEE ATTACHMENT B)</p> <p>In an effort to ensure the above solutions are sustained into the future, the Medical Social Services Coordinators shall include the "Focus on Abuse and Neglect Prohibition Practices" in each new employee orientation, in Annual Skills Validations of current employees and during Annual Mandatory Resident Rights Training. The Administrator, the DON and the VPCS will each conduct 5 spontaneous interviews of staff randomly selected each quarter of 2015, to ensure continued understanding of these practices. A report detailing the findings of the spontaneous shall be submitted to the Risk Management Committee and likewise to the Quality Improvement Committee quarterly in February, May,</p>	



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F 226		F 226	August and November 2015. (SEE ATTACHMENT C)  All unusual occurrences, reports and Summaries of Findings submitted to the OIG for suspected abuse and neglect shall be reviewed by the Administrator to determine if timely reporting took place. Persons found to have not taken immediate action to protect residents, to remove the suspected perpetrator from all resident care, and to have immediately reported suspected abuse and neglect shall have individual retraining by the Staff Development Coordinator.		

