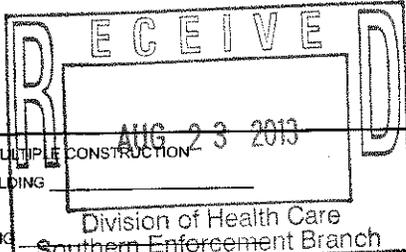


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/31/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
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 representative and to other officials in accordance	F 225	<b>F225</b>  On August 22, 2013 the violation was corrected.  Specific measures were utilized to correct the violation identified by surveyors; starting by completing a self-report to identify alleged injury of unknown source on August 22, 2013. The report was faxed to Office of Inspector General on August 22, 2013 at approximately 2:03pm, and to DCBS at 2:02 p.m.  The facility performed an audit to identify other residents to have the potential to be affected by the same practice. The audit was conducted by Executive Director, Jill Brown. Ms. Brown looked at each incident report of injury of unknown origin during the last six months to identify any non-compliance. Incidents were checked and compared to policy, if state agencies were notified; physician, family members, and 5 day follow up were all performed. The audit started on August 1 and was completed on August 22, 2013 with no negative findings. Ms. Brown also reported her audit and findings to the quality assurance committee.	

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

*Mark L. Spoh*

TITLE

*Adm.*

(X6) DATE

*8-23-13*

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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NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
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F 225	<p>Continued From page 1</p> <p>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 a review of facility policies it was determined the facility failed to ensure an injury of unknown source was reported to the state survey and certification agency as required for one of three sampled residents (Resident #1). On 07/19/13, staff discovered Resident #1 had a dislocation/injury to the left hip in absence of a known cause. A facility Investigation Report and interviews revealed an investigation was initiated in an attempt to determine the cause of the injury to Resident #1; however, the facility failed to report the injury of unknown source to state agencies as required.</p> <p>The findings include:</p> <p>The facility's policy/procedure, "Investigating Unexplained Injuries," dated 10/12/11, defined an injury of unknown source as an injury that was not observed by any person or could not be explained by the resident and would be considered suspicious because of the extent of the injury. The policy further stated an investigation would be conducted and the protocols set forth in the facility's established abuse investigation guidelines would be followed. A review of the facility's policy/procedure, "Reporting Abuse to State Agencies and Other Entities/Individuals," dated 10/11/12, revealed all suspected or</p>	F 225	<p>The facility put systemic changes in place by first updating the Investigating Unexplained Injuries Policy on August 1, 2013 and second by educating all nursing employees and Executive Director. The Executive Director received professional training by Lisa Hinkle on August 1, 2013. On August 2, 2013 Jill Brown Executive Director under the direction and oversight of Marlin Sparks Administrator educated nursing employees on Investigating Unexplained Injuries, Abuse police and procedure, Regulation F225, reporting immediately to the administrator or Executive Director, and injury tool. During the in-service training employees were given a tool to identify any injury that would need to be reported. Please see attachment. This tool is at each nurse's station for to assist staff and walking them through incident questions and reporting information. This is a tool only, not required as additional documentation at this time.</p> <p>The facility will monitor its performance to ensure that compliance is achieved by checking incident reports each day Monday through Friday (Saturday and Sunday reports will be reviewed on Monday) by DON, Executive Director or designee. During the check designee employee will be looking at each report to ensure policy and procedure has been followed, all documentation is complete, and each state agency has been notified if acceptable. The designee employee</p>		

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F 225	<p>Continued From page 2</p> <p>substantiated incidents of abuse would be immediately reported to appropriate state agencies as required.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 03/27/12 with diagnoses including Altered Mental Status, Dementia, and Dysarthria. A review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment completed on 06/21/13 revealed facility staff assessed the resident to have severe cognitive impairment and require extensive assistance of two staff members for bed mobility, and the activity of transferring/ambulating occurred only once or twice with physical assistance.</p> <p>A review of Resident #1's nurse's notes dated 07/19/13 and an interview with Licensed Practical Nurse (LPN) #12, on 07/30/13 at 1:23 PM, revealed at approximately 8:00 AM on 07/19/13, she was providing routine care to Resident #1, and discovered the resident's left hip appeared to be "out of socket." LPN #12 stated she immediately summoned the Charge Nurse to Resident #1's room. Interview with the Charge Nurse on 07/30/13 at 1:45 PM, revealed when she arrived in Resident #1's room and observed the resident's left hip, she "immediately knew something was wrong, you could see [his/her] femur, it looked like it was sticking up in [his/her] stomach." The Charge Nurse stated she called for the Nurse Consultant to also observe the injury and immediately contacted Resident #1's physician who ordered the resident to be transferred to the hospital for further evaluation and treatment.</p> <p>Interview with the Nurse Consultant on 07/30/13</p>	F 225	<p>will report all findings to the Quality Assurance Committee weekly.</p> <p>The facility was in substantial compliance on August 23, 2013.</p>		

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F 225	<p>Continued From page 3</p> <p>at 2:18 PM, and review of a written signed statement dated 07/19/13, revealed the Nurse Consultant and the staff assessing Resident #1 on 07/19/13, were unaware of how the injury had occurred to Resident #1, and stated the resident was also unable to communicate any information in regards to the injury. The Nurse Consultant stated she immediately initiated an investigation into the cause of the injury to Resident #1's left hip, including notifying the Director of Nursing and the Executive Director of the facility.</p> <p>Interview with the Executive Director (ED) of the facility on 07/30/13, at 2:10 PM revealed she was notified of the injury to Resident #1 on 07/30/13, soon after the injury had been discovered (exact time unknown). The ED stated she was responsible for all abuse notification to state officials. The ED stated the facility was notified at approximately 12:00 PM on 07/19/13, by the hospital, that Resident #1 had been diagnosed with a left hip fracture, and that the injury had been reported to Adult Protective Services due to the nature of the injury and inconsistent information from the facility as to how the injury had occurred. However, the ED stated the injury to Resident #1's left hip was not reported to the state agencies as required, because the facility's investigation had identified no suspicions that the injury had occurred as a result of abuse to Resident #1 and the facility had spoken to Resident #1's physician on 07/19/13 at 12:20 PM, and the physician had indicated it was a possibility that the injury to Resident #1's left hip was pathological in nature.</p>	F 225			