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

PRINTED: 03/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185346		R-C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 A Revisit Survey for Abbreviated Survey (#KY21175) was conducted in conjunction with the Recertification Survey on 03/11/14 through 03/13/14 and determined the deficiencies cited from the Abbreviated Survey were corrected on 02/28/14. The facility remained out of compliance with deficiencies cited on the Recertification Survey.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) 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.

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

RECEIVED
FEB 2014
OFFICE OF INSPECTOR GENERAL

PRINTED: 02/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER: HERMITAGE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1614 PARRISH AVE, WEST, OWENSBORO, KY 42301

(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 complaint #KY 21175 was conducted 01/15/14 through 01/21/14 to determine the facility's compliance with Federal requirements. #KY 21175 was substantiated with a deficiency cited at a Scope and Severity of a "G". On an unidentified date, Certified Nursing Assistant (CNA) #1 spilled urine in Resident #1's bed and did not change the bed when the resident asked to have his/her bed changed. This resulted in the resident sleeping in a wet bed that night. The CNA left the window open that night and it was a cold night. On 12/30/13, CNA #1 smacked Resident #1 on the hand and also manipulated the resident's leg into a position causing him/her pain. When the resident explained to the CNA he/she had surgery and the doctor requested his/her leg not be in that position, the CNA spoke inappropriately and said, "That doesn't hurt now does it?" to him/her. Resident #1 became anxious and had difficulty sleeping. Additionally, CNA #1 grabbed another resident (Resident #2) by the arms causing bruising to his/her bilateral arms. Resident #2 began having tearful episodes after the incident and required pharmaceutical intervention.	F 000	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers it response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223	1. Resident #1 was assessed by the Director of Nursing and the Assistant Director of Nursing on 12/30/13 with no negative outcomes. Resident #2 was accessed by the Director of Nursing and Assistant Director of Nursing on 12/30/13 with negative findings of discolorations to bilateral forearms. No other residents were affected by the alleged deficient practice. Certified Nursing Assistant #1 was immediately suspended for the alleged abuse allegation. Local police department were notified of the abuse allegation on 12/31/13 by the Director of Nursing.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: NHA (X6) DATE: 2/14/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Abuse/Neglect policy and procedure, the facility's investigation, facesheets, Minimum Data Set (MDS) assessments, police report, and Nurses' Notes, it was determined the facility failed to ensure two (2) of four (4) sampled residents (Resident #1 and Resident #2) were free from abuse. Certified Nursing Assistant (CNA) #1 spilled urine in Resident #1's bed, did not change the bed, then left the window open when it was a cold night. On another occasion, CNA #1 manipulated Resident #1's leg into a position by crossing his/her legs to put on shoes causing the resident pain. Interview with the resident revealed the CNA pushed his/her leg which caused his/her right foot to hit the floor, pulled his/her right leg up by the pant leg, placed it back on the resident's left knee, got in his/her face and said, "That doesn't hurt now does it?" Interview with Resident #1's family member revealed he/she was informed by the resident that CNA #1 had been saying the resident was stupid and crazy. Resident #1 also became anxious and had difficulty sleeping. Additionally, CNA #1 grabbed Resident #2 by his/her arms causing bruising to the resident's bilateral arms. Resident #2 began having tearful episodes after the incident and required pharmaceutical intervention. The findings include: Review of the facility's policy titled, "ABUSE, NEGLECT AND MISAPPROPRIATION", last	F 223	2. All other residents were interviewed regarding abuse and neglect, including the care they receive from facility staff by the Medical Records Director, Quality of Life Director, Medical Records Assistant, Dietary Manager, Business Office Manager, MDS Coordinator's, Director of Nursing, Rehab Manager, Assistant Director's of Nursing, Restorative Manager, Human Resources Director, Admissions Nurse, Staff Development Coordinator, and the Environmental Services Director on 12/31/13 with no negative findings. The Restorative Manager, Admissions Nurse, Medical Records Assistant, Assistant Director's of Nursing, Medical Records Director, and the Staff Development Coordinator accessed all other resident's skin to ensure no other residents were affected by the alleged deficient practice on 1/1/14, 1/2/14, and 1/3/14 with no negative findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 2 revised 03/2013, revealed verbal, sexual, physical and mental abuse, corporal punishment, neglect and involuntary seclusion of the resident, resident exploitation as well as misappropriation of resident property are prohibited. 1. Record review revealed the facility admitted Resident #1 on 12/09/13 with diagnoses which included Parkinson's and Hip Fracture with Arthroplasty. The resident was admitted for short term rehabilitation and the plan was for the resident to return home. Review of the Admission MDS assessment, dated 12/16/13, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. The facility assessed the resident as requiring extensive assistance with transfers and dressing. Review of the facility's Investigation Summary, revealed on 12/30/13 at 2:30 PM, Resident #1's family member reported to the facility Resident #1 had disclosed dissatisfaction with the care provided by CNA #1 during the previous night and on another night. Further review of the Investigation Summary revealed on one occasion (date uncertain), CNA #1 had spilled urine from a bed pan onto the resident's bed and refused to clean it up resulting in Resident #1 sleeping in a wet bed that night. That same evening, the CNA refused to close an open window in the resident's room which resulted in the resident being wet and cold. In addition, on the morning of 12/30/13, CNA #1 became impatient and smacked Resident #1 on the hand stating he/she was taking too long to put on his/her socks and shoes. CNA #1 made Resident #1 cross his/her legs placing the right ankle on the left knee causing	F 223	3. Staff was in-serviced by the Staff Development Coordinator beginning on 12/30/13 on facility Abuse and Neglect policy. On 1/24/14, staff was in-serviced by the Assistant Director of Nursing and the Staff Development Coordinator on the Elder Abuse Justice Act, Abuse and Neglect, Resident Rights, Job Burnout, and Domestic Violence. In addition to above stated education, the Licensed Nursing Staff, Certified Medication Aides, and the Certified Nursing Assistants receive continuing education on Abuse and Neglect from the Staff Development Coordinator on the weekly communication form. Certified Nursing Assistant #1 was terminated as a result of the abuse allegation being substantiated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 3 Resident #1 pain. Resident #1 told CNA #1 he/she felt pain and the doctor had instructed him/her not to position his/her legs in that manner due to recent hip surgery. CNA #1 argued back saying the doctor was wrong. The report revealed CNA #1 then pushed the resident's elevated foot causing it to drop to the floor. CNA #1 then pulled the cuff on the resident's right pant leg physically manipulating Resident #1 to cross his/her legs stating "see that didn't hurt anything did it?" Observation, on 01/15/14 at 1:30 PM, revealed Resident #1 was dressed in pants, a blouse and shoes. Interview with the resident, at this time, revealed several days back, CNA #1 had spilled urine from a bedpan onto the bed and did not change the bed linens. The resident stated the window was open and CNA #1 refused to close it. Resident #1 stated CNA #1 said it was closed, but he/she knew it was open as he/she could see some greeting cards blowing in the breeze and he/she was cold. In addition, Resident #1 revealed on 12/30/13, CNA #1 made him/her cross his/her legs to put on shoes. Resident #1 went on to explain that the doctor had instructed him/her not to do that as it would cause his/her hip to "pop out". Resident #1 stated the CNA then pushed his/her leg causing the right foot to hit the floor, the CNA then pulled the resident's right leg up by the pant leg placing it back on the left knee and got in his/her face and said, "That doesn't hurt now does it?" Resident #1 stated it made him/her "feel bad" when it happened and that he/she couldn't sleep at night until he/she knew CNA #1 was not going to come back to work.	F 223	4. The Business Office Manager, MDS Coordinator's, Human Resource Director, Admissions and Marketing Director, Quality of Life Director, Plant Operations Manager, Medical Records Director, Medical Records Assistant, Restorative Manager, Assistant Director's of Nursing, Environmental Services Director, Dietary Manager, Staff Development Coordinator, Chaplain, and the Admissions Nurse will conduct weekly resident interviews regarding care services provided by facility staff and report findings to the Director of Nursing and the Administrator. The Director of Nursing will report findings monthly to the Quality Assurance Team for 3 months for recommendations and follow-up. The Business Office Manager, MDS Coordinator's, Human Resource Director, Admissions and Marketing Director, Quality of Life Director, Plant Operations Manager, Medical Records Director, Medical Records Assistant, Restorative Manager, Assistant Director's of Nursing, Environmental Services Director, Dietary Manager, Staff Development Coordinator, Chaplain, and the Admissions Nurse will conduct weekly staff interviews regarding abuse and neglect and report findings to the Director of Nursing and the Administrator. The Director of Nursing will report findings monthly to the Quality Assurance Team for 3 months for recommendations and follow-up. 5. Corrective Action Date: 2/28/14	2/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 4 Interview with the Director of Nursing (DON), on 01/15/14 at 4:20 PM, revealed Resident #1's family members reported to her that CNA #1 left Resident #1's bed wet with urine and the window open. The family told the DON that it was twenty three (23) degrees (Farenheit) outside that night. The resident's family reported Resident #1 was crying and told them CNA #1 had slapped his/her hand and snatched his/her shoes from his/her hand. The family stated the CNA made the resident cross his/her legs, then moved the resident's legs, causing the resident's right leg to drop to the floor, then picked up his/her right leg by the pant cuff and manipulated the resident's right leg to cross. The CNA then looked the resident in the face and said "see, now that didn't hurt anything did it?" The facility initiated an investigation immediately. The facility suspended CNA #1. The allegation was substantiated and CNA #1 was terminated. Review of a Nurse's Note, dated 01/03/14 (no time) written by Registered Nurse (RN) #1, revealed "Resident more at ease today, I spoke with [him/her] about [his/her] restless nights. [He/she] stated (the alleged abuser's name), and I assured [him/her] that [he/she] was not going to have to contend with the alleged abuser any more and that the matter is being dealt with in the appropriate manner. [He/she] stated relief and was in a good mood today". Further review of the Nurse's Notes revealed no documented evidence the resident had restless or sleepless behaviors prior to the incident on 12/30/13. Interview with RN #1, on 01/16/14 at 1:45 PM, revealed he went to speak with Resident #1 after seeing documentation on a Situation/Background/Assessment or	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 5 Appearance/Request (SBAR) Communication form that the resident was not sleeping. He stated he talked with Resident #1 who said he/she "was pretty scared" and was having trouble sleeping. RN #1 stated the resident called CNA #1 by name, and identified this CNA as the person he/she was afraid of. He ensured the resident was safe and all had been taken care of, and the resident seemed more at ease. Interview with Resident #1's family member, on 01/16/14 at 10:00 AM, revealed Resident #1 informed the family member on 12/30/13 that CNA #1 had been saying he/she was stupid and crazy and had made Resident #1 cross his/her legs. Resident #1 also told the family member of an incident when CNA #1 spilled urine on the bed and left it and had refused to close an opened window at the time. The family member stated Resident #1 had a good memory and was scared of CNA #1 hurting his/her leg. Resident #1 would stay awake worried about CNA #1 coming into his/her room, but now he/she feels better since he/she was told CNA #1 would never be back. Review of a Police Report, obtained on 01/17/14, revealed the time of the occurrence was 12/30/13 at approximately 5:00 AM. Resident #1's statements were in corroboration with the facility's allegation and Resident #1 was visually upset about the incident as he/she cried when he/she was giving the Officer his/her statement. Interview with the investigating Police Officer, on 01/17/14 at 3:25 PM, revealed Resident #1 had said CNA #1 was mentally abusive and disrespectful. Further interview with the Police Officer revealed the resident was crying during their interview.	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 6 2. Record review revealed the facility admitted Resident #2 on 02/24/12 with diagnoses which included an Abnormal Gait, Chronic Airway Obstruction, History of Pelvic Fracture and History of Seizures. Review of the Annual MDS assessment, dated 10/05/13, revealed the facility assessed the resident's cognition as moderately impaired with a BIMS score of ten (10). The resident required extensive assistance with transfers, dressing and grooming and had a hearing impairment. The resident was alert, oriented, could express needs and wants, was cooperative with care and had no behaviors. On 12/30/13, during the facility's investigation of alleged abuse of Resident #1, Resident #2 was interviewed. Resident #2 also alleged rough treatment from CNA #1 that caused bruising to his/her bilateral arms. Resident #2 told facility staff that CNA #1 had caused bruising to his/her arms that morning when she got the resident up for the day. During the interview, the resident stated, "I don't know what I ever did to make her mad at me". The facility identified bruising on the resident's bilateral forearms that was purple in color and circular in shape measuring 7 (seven) centimeters (cm) by 5 (five) cm on the right arm; and, 5 (five) cm by 6 (six) cm on the left arm. According to staff observations, Resident #2 began to have tearful episodes after the experience with CNA #1 on 12/30/13. Review of a Physician's Order, dated 12/31/13, revealed Zoloft 25 milligrams (mg) was ordered due to Resident #2's tearfulness. Review of a Psychotropic Medication Consent form, dated 12/31/13, revealed the targeted behavior was "crying". Resident #2 had no previous diagnosis	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 223	Continued From page 7 of depression or behaviors of tearfulness. Psychiatric services were declined by the resident's family on 01/04/14. Observation, on 01/15/14 at 2:00 PM, revealed Resident #2 was sitting in a low seated wheelchair. Interview with the resident, at this time, revealed on 12/30/13, he/she was half asleep when CNA #1 "just grabbed me (demonstrated with clinched fists) like she was shaking something, it was my body". Resident #2 stated his/her arms were sore but better now. The resident stated he/she did not know why CNA #1 was mad at him/her. Further observation revealed the resident had quarter sized, faint greenish faded circular areas on both forearms. An additional observation, on 01/21/14 at 1:00 PM, revealed Resident #2 sitting in a wheel chair looking out the window by the facility dining room. The resident was tearful at the time but insisted he/she was fine. The resident stated twice "I'm fine, its nothing" and "It's ok, I'm fine". He/she did not want to talk at the time. Interview with the DON, on 01/15/14 at 4:20 PM, revealed Resident #2 was interviewed on 12/30/13 during a facility investigation regarding an abuse allegation of Resident #1. Resident #2 cried and continued to cry when interviewed. Resident #2 stated CNA #1 had grabbed his/her arms and the resident did not know why the CNA was mad at him/her. The DON talked with Resident #2 on 12/31/13. Resident #2 had informed the DON that his/her call light was on the floor so CNA #1 yelled at him/her for calling out. The resident stated the CNA grabbed him/her by the arms and told him/her to shut up. The resident told CNA #1 she did not have to be so	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER: HERMITAGE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1614 PARRISH AVE, WEST, OWENSBORO, KY 42301

(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 223	Continued From page 8 rough. The DON said Resident #2 had visible discolorations on both the right and left forearms. Further interview revealed the marks were red and purple and circular in shape. The police were notified and investigated the incident on 12/31/13. The Police Officers stated the discolorations on Resident #2's arms were "grab marks". Further interview with the DON, on 01/16/14 at 7:30 AM, revealed Resident #2 had cried and continued to cry when he/she talked with about the incident on 12/30/13. The Physician was notified and a new order for Zoloft 25 mg daily (antidepressant) was ordered. Review of a Police Report, obtained on 01/17/14, revealed the date and time of occurrence was on 12/30/13 at approximately 5:00 AM. Further review of the Police Report revealed, evidence listed as: Officer observed bruises in question which were located in the same area of both the left and right arm. Both bruises were the same color and seemed to be consistent with Resident #2's arms being held down. The Police Officer submitted photos taken of the victim for evidence. Interview with the investigating Police Officer, on 01/17/14 at 3:25 PM, revealed Resident #2 had stated he/she was sleepy that morning (12/30/13) and CNA #1 was agitated and grabbed him/her by the arms. The officer stated he saw bruises on both arms in the same location and the bruising coincided with grabbing. Interview with the Administrator, on 01/21/14 at 11:30 AM, revealed there were red flags noted from the facility's investigation and he could not say for certain CNA #1 did what was alleged but he certainly did not want her as an employee.	F 223		

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

PRINTED: 02/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185346		C 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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