

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/15/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
(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	1. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, will be immediately reported to officials in accordance with state law through established procedures (including to the state survey and certification agency) at the start of the facility investigation.	
F 225 SS-D	<p>AMENDED</p> <p>An abbreviated survey (KY #19631) was conducted on 01/14/13 to determine the facility's compliance with Federal requirements. KY #19631 was substantiated with deficiencies. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>	F 225	<p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. The facility policy, "Adult and Child Abuse and Neglect, Misappropriation of resident Property, Unexpected/Suspicious Death", has been changed to reflect proper timing of notifications as required by law.</p> <p>4. All documentation related to alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, will be reviewed by the facility social worker to assure compliance to policy. Furthermore, the Administrator, or designee, will notify QA upon knowledge of alleged violations and QA will monitor each allegation to assure notification within legal requirements.</p> <p>5. Completion date: January 31, 2013</p>	1-31-13

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



TITLE

ADMINISTRATOR

(X5) DATE

3/27/13

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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FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated 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 record review, interview and review of the facility's policy/procedure, it was determined the facility failed to report to the proper authorities an allegation of abuse of one resident (#1), in the selected sample of three residents. On 12/24/12, the facility was notified by Resident #2 that Certified Nurse Assistant (CNA) #2 had slapped Resident #1 and did not report the allegation to the appropriate authorities.</p> <p>Findings include:</p> <p>Review of the facility's policy titled "Adult and Child Abuse and Neglect, Misappropriation of Resident Property, Unexpected/Suspicious Death Policy", no date, revealed the employee will report immediately to the Supervisor, Director of Nursing or Administrator. The Administrator or his designee will contact the authorities within legal requirements.</p> <p>Interview with CNA #1, on 01/15/13 at 10:52 AM, revealed Resident #2 reported to her that CNA #2 had slapped his/her room mate (Resident #1). CNA #1 stated she immediately called the</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>Administrator to report this incident. She revealed the Administrator came in to the facility and started an investigation.</p> <p>Review of the facility's investigation revealed the investigation was initiated on 12/24/12 and the facility unsubstantiated the allegation on 12/26/13. There was no evidence the facility reported the allegation of abuse to the appropriate authorities.</p> <p>Interview with the Administrator, on 01/14/13 at 12:00 PM, revealed he received a call on 12/24/12 at 6:00 PM from CNA #1 and the CNA reported Resident #2 had told her that CNA #2 had slapped Resident #1. The Administrator revealed he started an investigation immediately. The Administrator revealed he unsubstantiated the allegation and did not notify the appropriate authorities because he had determined the allegation was unsubstantiated.</p>	F 225			