

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

PRINTED: 12/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185302</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/15/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HARDINSBURG NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 FAIRGROUNDS ROAD</b> <b>HARDINSBURG, KY 40143</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}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/15/14 as alleged.</p>	{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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/19/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  HARDINSBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143
---	--

(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
--------------------	--	---------------	---	----------------------

<p>F 000 INITIAL COMMENTS</p> <p>F 225 SS=D</p>	<p>An Abbreviated Survey was conducted on 11/19/14 to investigate KY22486. The Division of Health Care substantiated the allegation with deficiencies cited.</p> <p>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 to the administrator or his designated representative and to other officials in accordance</p>	<p>F 000</p> <p>F 225</p>	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	<p>HL</p> <p>12/10/14</p>
---	--	---------------------------	--	---------------------------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X *Jamie Powers* TITLE: X Admin (X6) DATE: X 12/10/14

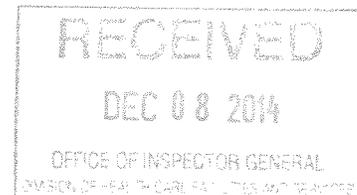
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

DEC 08 2014  
OFFICE OF INSPECTION  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143	
(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 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 observation, interview, record review, and review of the facility's investigation report and abuse policy, it was determined the facility failed to have an effective system in place to ensure all allegations of abuse, including verbal, were investigated and reported to ensure residents were protected from further abuse for one (1) of four (4) sampled residents, Residents #1.</p> <p>Upon receipt of an allegation of verbal abuse, the facility's administration failed to protect residents by allowing the alleged perpetrator to continue providing direct care to residents including Resident #1. The facility failed to immediately initiate an investigation and failed to report the allegation to the state agencies until two days after the alleged verbal abuse had occurred.</p> <p>The findings include:</p> <p>Review of the facility's Abuse policy, not dated, revealed the resident had the right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion. The definition of verbal abuse was the use of oral, written or gestured language, that willfully included disparaging and derogatory terms to residents within hearing distance, regardless of their age, ability to comprehend, or disability. Under the investigation portion of the policy</p>	F 225	<p>1. The Regional Director of Operations re-educated the Administrator on Abuse and Neglect including the policy of immediate suspension/ protection, investigation and timely reporting on 11/4/14. LPN # 2 was suspended on 11/4/14 and an investigation was completed on 11/7/14. An initial report was filed with the Office of Inspector General on 11/4/14 with the final report being submitted on 11/7/14. Resident # 1 was interviewed by the Administrator on 11/4/14 and could not remember the incident and did not appear to be fearful or withdrawn. LPN # 2 was terminated on 11/7/14</p> <p>2. All alert and orientated residents with a BIMs score of eight (8) or greater was interviewed by the Director of Nursing and Assistant Director of Nursing on 11/19/14 to determine any current allegations of abuse or neglect. All residents with a BIMs score of less than eight (8) will have an assessment completed by the Director of Nursing, Assistant Directors of Nursing to identify any suspicion of abuse or neglect. Any allegations of abuse or neglect will be reported and investigated with</p> <p>12/15/14</p>



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

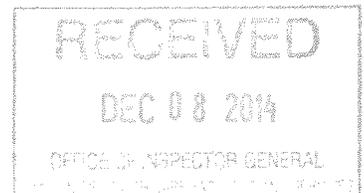
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 225	<p>Continued From page 2</p> <p>revealed any persons who suspected abuse, neglect, or misappropriation of property to have occurred, would immediately report the alleged violation to the facility administration. The facility administration would immediately suspend the staff person who was alleged to have or to be suspected of abuse and/or neglect, and, notify the Office of Inspector General, Adult Protective Services, and local law enforcement authority. The facility administration would initiate the investigation process by interviewing all staff and residents having any knowledge of the allegation immediately. If the complaint alleged abuse by staff, the facility would take steps to protect the residents from any further abuse. This would include suspension of the staff member who was named in the allegation until the investigation had been completed.</p> <p>Review of the facility's investigation, dated xx/xx/xx, revealed the investigation was initiated on 11/04/14, two days after the allegation was received. The investigation included written statements from the witnesses and the alleged perpetrator. It also included a written account by the Administrator. The investigation had a confirmed fax date of 11/04/14 at 2:25 PM to the Office of Inspector General indicating notification; however, the alleged verbal abuse occurred on 11/02/14. The investigation revealed the facility did not substantiate abuse due to the resident not remembering any of the incident.</p> <p>Review of Resident #1's clinical record revealed the resident had resided at the nursing facility since 09/02/13. The diagnoses of Dementia with Behaviors, Alzheimer's Disease, History of falls, Impulse Control, Anxiety, Psychosis (03/23/13), and Diabetes was listed. The facility assessed</p>	F 225	<p>appropriate staff suspended as appropriate. This will be completed by 12/12/14.</p> <p>3. The Regional Director of Operations re-educated the Administrator on Abuse and Neglect including the policy of immediate suspension, protection, investigation and timely reporting on 11/4/2014. The Administrator completed a competency test on 12/1/14 for abuse and neglect and competency was validated by the Regional Director of Operations on 12/1/14. The Administrator will re-educate the Director of Nursing, Assistant Directors of Nursing and Social Service Director on 12/2/14 on abuse and neglect policy and complete competency test. All facility staff will be re-educated on Abuse and Neglect policy by the Administrator and Director of Nursing including competency testing by 12/12/14 with no staff working after 12/13/14 without having received this re-education.</p> <p>4. The Administrator, Director of Nursing or Assistant Director of Nursing will complete questionnaires with five (5) staff per week for twelve (12) weeks and five (5) staff</p>	



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

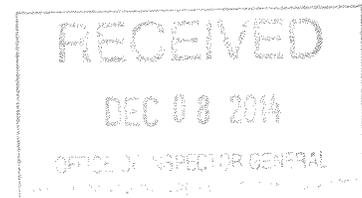
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185302</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>11/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARDINBURG NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 FAIRGROUNDS ROAD HARDINBURG, KY 40143</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 225	<p>Continued From page 3</p> <p>the resident to have a severe cognitive impairment (Brief Interview Mental Status score of a 3 out of possible 15) and assessed the resident to required extensive assistance from staff for eating. Review of the behavioral care plan, dated 09/29/14, revealed the resident exhibited mood/behaviors that included verbal and physical abuse, yelling/cursing, socially inappropriate, throws food, water, sexual inappropriate comments toward staff, and rejects care during meals, baths, and other activities of daily living. The care plan directed the staff to approach the resident in a calm manner and avoid confrontation when agitated. The clinical record revealed Psych services was provided and the resident was currently receiving psychotropic medications.</p> <p>Observation of Resident #1, on 11/19/14 at 9:05 AM, revealed the resident sitting in a Broda chair in the common area. Interview with the resident revealed the resident could not recall the incident and when asked if anyone had ever told him/her to shut up, the resident said, "no", and laughed.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 11/19/14 at 11:00 AM, revealed she was assisting residents in the restorative dining room on 11/02/14 during the evening meal. She revealed License Practical Nurse (LPN) #1 and #2 were also in the dining room assisting residents. She stated she overheard LPN #2 tell Resident #1 to shut up. She indicated the resident needs assistance with eating and will chew and chew on a small bit of food. She stated she over heard LPN #2 ask the resident to open his/her mouth. The resident started cursing the nurse and that's when she heard LPN #2 tell Resident #1 to shut up. She said LPN #1 asked</p>	F 225	<p>per month for six (6) months to ensure staff understanding of the abuse and neglect policy. The results of these questionnaires will be reviewed with the Quality Assurance Committee at least monthly for nine (9) months or until the Quality Assurance Committee deems appropriate to decrease. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Director with the Medical Director attending at least quarterly.</p>	



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

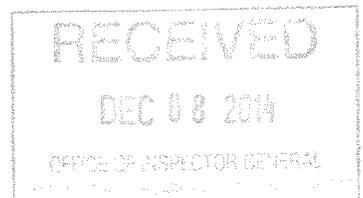
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 225	Continued From page 4  the other nurse if she needed to take over the care of Resident #1 and LPN #2 said, "No" and continued to feed the resident. She stated it was the tone of the nurse's voice that concerned her and she felt it was inappropriate language to use with a resident. She stated the nurse was apparently upset and used a stern tone of voice. She stated she felt uncomfortable and left the dining room to report the incident to the Administrator. She found the Administrator in the other dining room (not attached) and informed her of what she had seen and heard. She revealed the Administrator did not request a written statement that day. The CNA was called later and a written statement was requested. She revealed she left work right after the evening meal around 6:00 PM and did not know if LPN #2 continued to work.  Interview with LPN #1, on 11/19/14 at 11:15 AM, revealed she was in the restorative dining room during the evening meal on 11/02/14 assisting residents with eating. She confirmed CNA #1 and LPN #2 was in the dining room also. She revealed LPN #2 was feeding Resident #1. She said she heard Resident #1 tell LPN #2 to get his F...ing hands off him/her. She stated she observed LPN #2 point his finger in Resident #1's face and told him to "shut up". She stated the nurse was clearly upset and anger. She stated she offered to feed the resident but LPN #2 said he was fine and continued feeding the resident without any other incident. She said the resident continued to eat and ate all of the food provided. The nurse appeared to have calmed down and the resident did not appear to be upset. She indicated she would have reported the alleged verbal abuse, but she knew CNA #1 had left to report the incident. She stated the Administrator	F 225			



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

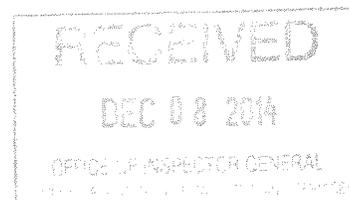
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 225	<p>Continued From page 5</p> <p>did not come into the dining room during the meal and she did not question her about the incident. LPN #2 continued to work and care for residents after the incident. However, the nurse was not assigned to Resident #1's hall.</p> <p>Interview with LPN #2, on 11/19/14 at 12:47 PM, revealed he was in the restorative dining room assisting Resident #1 with the evening meal on 11/02/14 when the resident started cursing him. The nurse stated the resident had a habit of chewing on small bits of food (the resident was on mechanical soft diet) and the nurse wanted the resident to open his/her mouth so he could see if there was any actual food in the resident's mouth. When the resident opened his/her mouth, the nurse said he did a finger sweep to determine if there was food lodged in the back of the mouth. When he did this, the nurse said the resident starting cursing and calling him bad names. The nurse revealed he shook his finger in the resident's face and told him in a stern voice, "that is enough." The nurse stated he just reacted to the resident's name calling and because he was angry. He denied he told the resident to shut up. The nurse indicated the resident had a history of cursing staff but usually if you talked with the resident he/she would calm down. The nurse related he should not have reacted to the resident's behaviors and should not have raised his voice with the resident.</p> <p>Continued interview with LPN #2 revealed he had worked at the facility for almost three (3) years and had been trained on abuse. The nurse stated his definition of verbal abuse would be to curse or threaten a resident. He said when he raised his voice to the resident it was inappropriate, but he didn't think it was abuse. He stated LPN #1</p>	F 225		



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

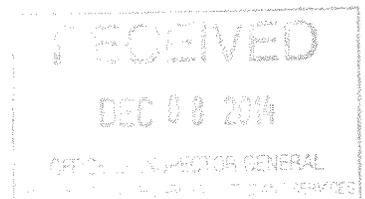
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 225	Continued From page 6 offered to finish feeding Resident #1 but he declined because the resident did not exhibit anymore behaviors and ate the rest of the meal without any problems. He confirmed he finished his work shift at 10:00 PM and provided care to residents. He stated the Administrator did not talk with him that evening and he was off the following day. On 11/04/14, he was called and told to come to the facility. Upon his arrival, he was interviewed about the incident and requested to complete a written account. He stated that's when the Administrator told LPN #2 that he was suspended pending investigation. Three days later he received a call from the Administrator telling him he was terminated.  A telephone interview with the Administrator, on 11/19/14 at 9:40 AM, revealed she was at the facility the day of the alleged verbal abuse. She stated she was assisting residents in the other dining room and could not hear or see the restorative dining room from that location. She stated CNA #1 reported Resident #1 had cursed LPN #2 and the nurse had told the resident to shut up. She stated she went and stood outside the restorative dining room to watch and listen. However, she did not remove LPN # 2 from feeding the resident. She said Resident #1 was not exhibiting any behaviors while she watched and LPN #2 did not do or say anything inappropriate. She indicated the resident was not upset and continued to eat his/her food. She stated she did not interview LPN #1 or LPN #2 that night and allowed LPN #2 to continue working until the end of his work shift at 10:00 PM, several hours after the evening meal. The Administrator indicated she left the facility after the evening meal. She said she called the Regional Nurse Consultant on 11/04/14 and	F 225			



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

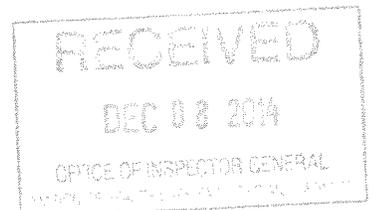
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 225	Continued From page 7 reported the incident. The consultant instructed the Administrator to report the incident to the Office of Inspector General. She indicated she had already initiated the investigation and suspended LPN #2.  Continued interview with the Administrator revealed there were only three staff in the restorative dining room that evening: CNA #1 and LPN #1 & 2. She remarked she did not interview any dietary staff to determine if they may have seen or heard anything. The kitchen connects to the restorative dining room and had a open window where dietary staff could look into the dining room. The Administrator stated CNA #1 was reluctant for her to speak with LPN #2 because she was concern he would know she was the person who reported the incident. The Administrator stated she should have removed LPN #2 that evening and started the investigation. She did not think it was a reportable allegation because she felt the nurse's behavior was inappropriate but did not consider it to be verbal abuse. She stated staff were being retrained on the abuse policy. The Director of Nursing and herself was conducting the training. However, review of the training roster revealed more than forty (40) employees had not been trained including LPN #1.  The Administrator further stated LPN # 2 should have been removed from resident care that evening. She acknowledged CNA #1 did report immediately, but she failed to follow the abuse policy and suspend the nurse per policy.	F 225			
F 226	483.13(c) DEVELOP/IMPLMENT SS=D ABUSE/NEGLECT, ETC POLICIES	F 226			



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

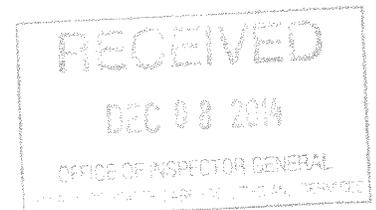
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 226	Continued From page 8 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 interview, record review, and review of the facility's investigation report and abuse policy, it was determined the facility failed to have an effective system in place to ensure the facility's policies and procedures related to abuse were implemented for one (1) of four (4) sampled residents, Resident #1. Upon receipt of an allegation of verbal abuse, the facility's administration failed to suspend the alleged staff per abuse policy and allowed the staff to continue providing direct care to residents. The facility failed to immediately initiate an investigation and failed to report to the state agencies with a delay of two days after the alleged verbal abuse occurred.  The findings include:  Review of the facility's Abuse policy, not dated, revealed the resident had the right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion. The definition of verbal abuse was the use of oral, written or gestured language, that willfully included disparaging and derogatory terms to residents within hearing distance, regardless of their age, ability to comprehend, or disability. Under the investigation portion the policy stated any persons who suspected abuse, neglect, or misappropriation of property to have occurred,	F 226	1. The Regional Director of Operations re-educated the Administrator on Abuse and Neglect including the policy of immediate suspension/ protection, investigation and timely reporting on 11/4/14. LPN # 2 was suspended on 11/4/14 and an investigation was completed on 11/7/14. An initial report was filed with the Office of Inspector General on 11/4/14 with the final report being submitted on 11/7/14. Resident # 1 was interviewed by the Administrator on 11/4/14 and could not remember the incident and did not appear to be fearful or withdrawn. LPN # 2 was terminated on 11/7/14  2. All alert and orientated residents with a BIMs score of eight (8) or greater was interviewed by the Director of Nursing and Assistant Director of Nursing on 11/19/14 to determine any current allegations of abuse or neglect. All residents with a BIMs score of less than eight (8) will have an assessment completed by the Director of Nursing, Assistant Directors of Nursing to identify any suspicion of abuse or neglect. Any allegations of abuse or neglect will be reported and investigated with	12/15/14	



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

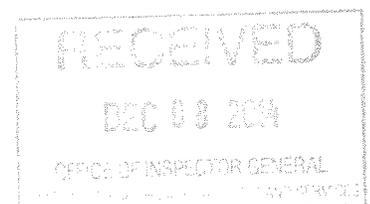
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185302</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARDINSBURG NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143</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 226	<p>Continued From page 9</p> <p>would immediately report the alleged violation to the facility administration. The facility administration would immediately suspend staff who are alleged to have or to be suspected of abuse and/or neglect, and notify the Office of Inspector General, Adult Protective Services, and local law enforcement authority. The facility administration would initiate the investigation process by interviewing all staff and residents having any knowledge of the allegation immediately. If the complaint alleged abuse by staff, the facility would take steps to protect the residents from any further abuse. This would include suspension of the staff member who was named in the allegation until the investigation had been completed.</p> <p>Review of the facility's investigation, dated xx/xx/xx, revealed the investigation was initiated on 11/04/14 and the Office of Inspector General and Adult Protective Services was notified of the alleged verbal abuse on 11/04/14 at 2:25 PM. However, the alleged verbal abuse occurred on 11/02/14. A written statement by the accused staff was not obtained until 11/04/14 and the staff member was suspended that day. The facility's investigation revealed the facility did not substantiate abuse due to the resident could not remember any of the incident.</p> <p>Interview with CNA #1, on 11/19/14 at 11:00 AM, revealed she was assisting residents in the restorative dining room on 11/02/14 during the evening meal. She revealed License Practical Nurse (LPN) #1 and #2 were also in the dining room assisting residents. She stated she overheard LPN #2 tell Resident #1 to shut up. She indicated the resident needed assistance with eating and would chew on small bits of food.</p>	F 226	<p>appropriate staff suspended as appropriate. This will be completed by 12/12/14.</p> <p>3. The Regional Director of Operations re-educated the Administrator on Abuse and Neglect including the policy of immediate suspension, protection, investigation and timely reporting on 11/4/2014. The Administrator completed a competency test on 12/1/14 for abuse and neglect and competency was validated by the Regional Director of Operations on 12/1/14. The Administrator will re-educate the Director of Nursing, Assistant Directors of Nursing and Social Service Director on 12/2/14 on abuse and neglect policy and complete competency test. All facility staff will be re-educated on Abuse and Neglect policy by the Administrator and Director of Nursing including competency testing by 12/12/14 with no staff working after 12/13/14 without having received this re-education.</p> <p>4. The Administrator, Director of Nursing or Assistant Director of Nursing will complete questionnaires with five (5) staff per week for twelve (12) weeks and five (5) staff</p>	



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

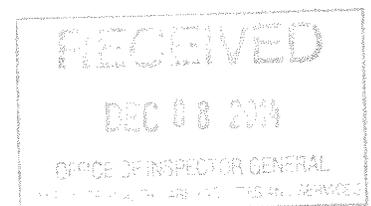
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 226	<p>Continued From page 10</p> <p>She stated she over heard the nurse ask the resident to open his/her mouth. The resident started cursing the nurse and that's when she heard LPN #2 tell Resident #1 to shut up. She said LPN #1 asked the other nurse if she needed to take over the care of Resident #1 and LPN #2 said, "No" and continued to feed the resident. She stated it was the tone of the nurse's voice and she felt it was inappropriate language to use with a resident. She stated she felt uncomfortable and left the dining room to report the incident to the Administrator. She found the Administrator in the other dining room and reported the incident. She said the Administrator did not request a written statement that day, but was called later with a request for a written statement. She remarked she left work right after the evening meal around 6:00 PM and did not know if LPN #2 continued to work.</p> <p>Interview with LPN #1, on 11/19/14 at 11:15 AM, revealed she was in the restorative dining room during the evening meal on 11/02/14 assisting residents with eating. She confirmed CNA #1 and LPN #2 was in the dining room also. She revealed LPN #2 was feeding Resident #1. She said she heard Resident #1 tell LPN #2 to get his f...ing hands off him/her. She stated she observed LPN #2 point his finger in Resident #1's face and told him to "shut up". She stated the nurse was clearly upset and angry. She stated she offered to feed the resident but LPN #2 said he was fine and continued feeding the resident. She stated the resident ate all of the food provided. She stated LPN #2 had calmed down and the resident did not appear to be upset. She indicated she would have reported the alleged verbal abuse but she knew CNA #1 had left to report the incident. She stated the Administrator</p>	F 226	<p>per month for six (6) months to ensure staff understanding of the abuse and neglect policy. The results of these questionnaires will be reviewed with the Quality Assurance Committee at least monthly for nine (9) months or until the Quality Assurance Committee deems appropriate to decrease. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Director with the Medical Director attending at least quarterly.</p>	



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

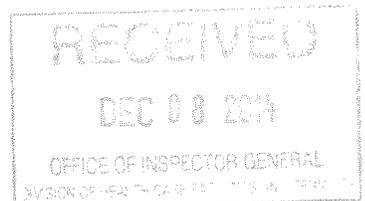
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 226	<p>Continued From page 11</p> <p>did not come into the dining room during the meal and she did not question this nurse. She revealed LPN #2 continued to work and care for residents after the incident.</p> <p>Interview with LPN #2, on 11/19/14 at 12:47 PM, revealed he was in the restorative dining room assisting Resident #1 with the evening meal on 11/02/14 when the resident started cursing him. The nurse stated the resident had a habit of chewing on small bits of food so the nurse wanted the resident to open their mouth so he could see if there was any actual food in the resident's mouth. When the resident opened their mouth, the nurse said he did a finger sweep to determine if there was food lodged in the back of the mouth. When he did this, the nurse said the resident starting cursing and calling him bad names. The nurse revealed he shook his finger in the resident's face and told him in a stern voice, "that is enough." The nurse stated he just reacted to the resident's name calling and acknowledged he was angry. He denied he told the resident to shut up. The LPN revealed the resident had a history of cursing staff, but usually if staff talked with the resident he/she would calm down. The nurse expressed he should not have reacted to the resident's behaviors and should not have raised his voice with the resident.</p> <p>Continued interview with LPN #2 revealed he had worked at the facility for almost three (3) years and had been trained on abuse. The nurse stated his definition of verbal abuse would be to curse or threaten a resident. He said when he raised his voice to the resident it was inappropriate, but he didn't think it was abuse. He stated LPN #1 offered to finish feeding Resident #1 but he declined because the resident was not cursing</p>	F 226		



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

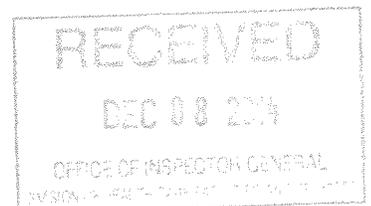
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 226	<p>Continued From page 12</p> <p>any more and ate the rest of the meal without any problem. He confirmed he finished his work shift at 10:00 PM and provided care to residents. He stated the Administrator did not talk with him that evening and he was off the following day. On 11/04/14, he was called and told to come to the facility. Upon his arrival, he was interviewed about the incident and requested to complete a written account. He stated that's when the Administrator told him he was suspended pending investigation. Three days later he received a call from the Administrator telling him he was terminated.</p> <p>A telephone interview with the Administrator, on 11/19/14 at 9:40 AM, revealed she was at the facility the day of the alleged verbal abuse. She stated she was assisting residents in the other dining room and could not hear or see the restorative dining room from that location. She revealed CNA #1 reported Resident #1 had cursed LPN #2 and the nurse told the resident to shut up. She stated she went and stood outside the restorative dining room to watch and listen. She said Resident #1 was not exhibiting any behaviors while she watched and LPN #2 did not do or say anything inappropriate. She indicated the resident was not upset and continued to eat his/her food. She said she did not go into the dining room and remove LPN #2 from Resident #1's care. She stated she did not interview LPN #1 or LPN #2 that night and allowed LPN #2 to finish his work shift that ended at 10:00 PM, several hours after the evening meal. The Administrator stated she left the facility after the evening meal. She called the Regional Nurse Consultant on 11/04/14 and reported the incident. The consultant instructed the Administrator to report the incident to the Office of Inspector General. She indicated she had already initiated</p>	F 226		



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143		
(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 226	Continued From page 13 the investigation and suspended LPN #2.  Continued interview with the Administrator revealed there were only three staff in the restorative dining room that evening: CNA # 1 and LPN #1 & 2. She indicated she did not interview any dietary staff to determine if they may have seen or heard anything. The kitchen connects to the restorative dining room and had an open window where staff could see into the dining room. The Administrator stated CNA #1 was reluctant for her to speak with LPN #2 because she was concerned he would know she was the person who reported the incident. The Administrator stated she should have removed LPN #2 that evening and started the investigation. She did not think it was a reportable allegation because she felt the nurse's behavior was inappropriate, but did not consider it to be verbal abuse. She stated staff were being retrained on the abuse policy. The Director of Nursing and herself was conducting the training. However, review of the training roster revealed more than forty (40) employees had not been trained including LPN #1.  The Administrator stated she was knowledgeable of the facility's Abuse policy and stated LPN #2 should have been removed from resident care that evening. She stated CNA #1 did report immediately, but she failed to follow the Abuse policy and suspend the nurse. She indicated she determined the final investigation reported the findings to the Office of Inspector General. Although she considered LPN #2's behavior to be inappropriate, she had not considered it to be verbal abuse.  Interview the the Director of Nursing, on 11/19/14	F 226			



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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/19/2014
NAME OF PROVIDER OR SUPPLIER  HARDINSBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143		
(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 226	Continued From page 14 at 2:51 PM, revealed she was in the process of getting everyone retrained on the abuse policy using a read and sign method. She stated on 11/04/14, she and the Administrator conducted on the spot training with some of the staff and revealed no classroom type of training had been conducted. She confirmed not all staff had been trained to date.	F 226			

