

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

PRINTED: 04/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203	

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INITIAL COMMENTS

An abbreviated survey was initiated 03/28/13 and concluded 03/29/13 for KY19921 and KY19922. KY19921 and KY19922 were substantiated with deficiencies cited.

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SS=D

483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, review of the clinical record, and review of the facility policy, it was determined the facility failed to investigate misappropriation allegations for two (2) of three (3) sampled (Residents #1 and #2) and three (3) un-sampled residents, (un-sampled Residents A, B & C). The investigation for Resident #1 did not include interviews with other residents or additional staff members, including a staff member identified in a written statement. The investigation for Resident #2 did not include statements from staff members or additional residents.

The findings include:

The facility policy Abuse and Reporting Prevention, not dated, revealed misappropriation of resident property, which included resident

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Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.

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1. The investigation was re-opened by the Administrator for res # 1 and res # 2 and all statements previously gathered from Res #1 and Res #2 and staff was reviewed by the Administrator on 3/29/13. Res #1 and #2 were interviewed again on 4/6/13 by the Social Services Director and on 4/1/13 by the Administrator and Admissions Coordinator respectively to determine if more information could be gathered related to the time lapse between the original investigation and the re-opening of the investigations. Statements were taken from additional staff members by the Administrator and Dept. Head Leaders to determine if more information could be determined. No further information was forthcoming. Res #1 and Res #2 were given a lockbox with a key on a lanyard by the Social Services Director on 3/18/13 to secure their belongings. Res #1 and # 2 currently have the lock box in their possession and acknowledge being able to use it properly.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

[Handwritten Signature]

TITLE

[Handwritten Signature]

(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.

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Continued From page 1

money, was a type of abuse. The purpose of the policy was to prevent any type of abuse to residents that included an investigation. Any reported abuse by residents or staff, a thorough investigation of the allegation would be conducted by the Administrator or designated facility staff. Additionally, if the report implicates an employee, the Administrator would determine if any action would be needed to prevent further potential abuse or allegations while the investigation was in progress, including removal of the staff from the schedule. All statements obtained during the course of the investigation should be put in writing.

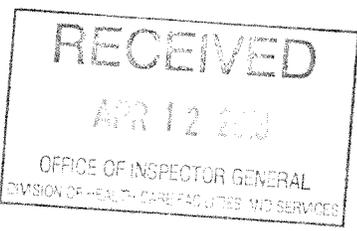
Review of the facility investigation for Resident #1, dated 03/11/13, revealed the resident reported he/she was missing \$15.00 from a drawer in the bedside cabinet. The resident reported the missing money directly to the Administrator. A written statement from Certified Nursing Assistant (CNA) #1 revealed the resident reported to the CNA that the previous aide was snooping in the resident's drawers and stole \$15.00. The investigation also included a statement from Licensed Practical Nurse (LPN) #1.

Review of the clinical record for Resident #1 revealed the facility admitted the resident on 12/03/12 with a diagnosis of Dementia. The facility assessed the resident, with an initial Minimum Data Set (MDS) on 12/10/12 with a Brief Interview Mental Status (BIMS) of six (6), as cognitively impaired.

Interview with Resident #1, on 03/28/13 at 8:30 AM, revealed night shift staff go through the

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2. All residents and/or their responsible parties were given a letter via hand delivery or US Postal Services on 4/12/13 detailing what is abuse, who to report suspected abuse to, how we protect our residents and how we investigate. They were also encouraged to inform the Administrator, SSD, or DON, or Charge Nurse of any concerns in which an investigation is desired.
3. All staff will be educated by the Administrator, Staff Development Coordinator, and/or Social Services Director on what is abuse, who to report suspected abuse to, how to protect residents when allegations of abuse are made and how to investigate abuse by 4/18/13. The Director of Clinical Services will in service the Administrator by 4/18/13 to follow up with the Social Services Director and the DON to ensure that all investigations of alleged abuse and neglect are complete.
4. All allegations of abuse and neglect will be audited Weekly x 12, bi monthly x 2, then monthly thereafter by the Administrator and Social Services Director to determine if the investigation was complete. Results of the audits will be reported to QA monthly for further recommendations.
5. All Corrective measures will be completed by 4/19/13.



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Continued From page 2
resident's things when he/she pretended to be asleep. The resident stated the money was in the drawer in the bedside cabinet and the staff took his/her money.

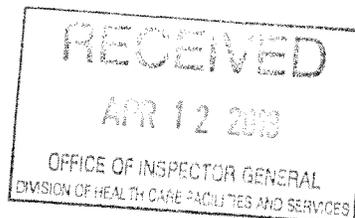
Review of Resident #2's facility investigation, dated 03/12/13, revealed the resident reported he/she was missing \$5.00 from the billfold kept in the bedside cabinet drawer. The resident reported the missing money to the Director of Nursing (DON). The written statement by the DON states staff that worked would be talked to. The investigation also included a written statement from the Director of Housekeeping that housekeepers were talked with.

Review of Resident #2's clinical record revealed the facility admitted the resident on 01/16/13 with a diagnosis of Spinal Stenosis. The facility assessed the resident with an initial MDS, on 01/23/13 with a BIMS of thirteen (13), as cognitively intact.

Interview, on 03/28/13 at 8:50 AM, with Resident #2 revealed the resident had the money in his/her billfold in the bedside cabinet drawer. The resident stated he/she went to eat in the dining room and about twenty (20) minutes later returned to his/her room and discovered the money missing.

On 03/28/13 at 9:45 AM, interview with CNA #1 revealed the aide was assigned to work with Resident #1 the morning the resident reported the missing money. The CNA stated the resident said the previous aide on third shift thought the resident was asleep and took the resident's money and the third shift aide goes through the

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Continued From page 3 resident's drawers often.

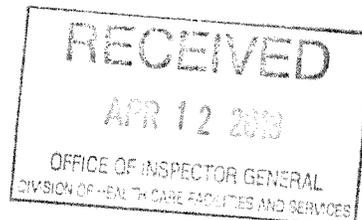
Interview, on 03/28/13 at 10:40 AM, with Housekeeper #4 revealed she was unaware of Residents #1 and #2 missing any money and were not interviewed nor statements requested by the facility.

Interview with LPN #2, on 03/28/13 at 10:50 AM, revealed she was aware Resident #1 had reported missing money and stated she worked with Resident #2 five (5) days a week. The LPN stated no one asked for her statement or talked with her regarding either residents' missing money.

On 03/28/13 at 11:05 AM, interview with Laundry Aide #3 revealed she was not aware of Resident #2's missing money until a few days ago.

Interview with CNA #4 revealed she worked with Resident #1 regularly. The CNA stated the resident informed her a particular third shift aide goes through the resident's belongings and goes through the resident's closet. The aide stated the hallway for Resident #1 on the third shift has only one CNA on duty. The CNA stated part of the aide's role may include getting a brief out of the closet for residents; however, the residents tell her they see the third shift aide going through their things. The CNA stated Resident #3, un-sampled Resident A, and un-sampled Resident B had reported the third shift aide to her. The aide stated she did not feel at the time it was misappropriation as no staff had reported anything missing. The CNA stated no one from the facility talked with her or requested a statement regarding Resident #1 or Resident #2's

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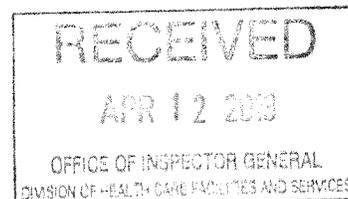
F 226	Continued From page 4 missing money.	F 226		
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Interview, on 03/28/13 at 12:55 PM, with CNA #2 revealed she had worked with Resident #2 previously, and was not aware the resident was missing money. The aide stated no one from the facility interviewed her about the resident's missing money.

Interview with un-sampled Resident A, on 03/28/13 at 2:25 PM, revealed one particular aide at night goes through the resident's belongings. The resident stated he/she has woken in the past and found the CNA going through his/her things.

Interview with un-sampled Resident C, on 03/28/13 at 3:10 PM, revealed staff go through the resident's drawers and closets during the day.

On 03/28/13 at 4:08 PM and continued on 03/29/13 at 9:47 AM, interview with the Social Service Director (SSD) revealed she had been employed with the facility for six (6) weeks. The SSD stated she was able to validate Residents' #1 and #2 both had the funds reported missing. She stated there were no additional statements obtained other than the CNA and nurse for the investigation related to Resident #1; or the DON and Director of Housekeeping for Resident #2. The SSD stated she was the primary coordinator in the facility's investigations. She stated the investigations for Resident #1 and Resident #2 were both given to the nursing department and DON for further investigation, who then report back to the SSD. The SSD stated she spoke with Resident #1 who stated an aide was involved but could not say who or when. She stated she did not read the two (2) statements given by staff for



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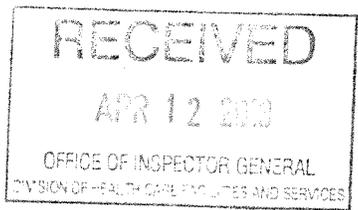
F 226 Continued From page 5

the investigation for Resident #1. She stated the DON was responsible to talk with the identified aide for the previous shift and was informed that the aide had been spoken to. She stated the department heads forward their findings to the SSD who then files the reports. She stated her role in interviewing involved the resident and resident's family. The SSD stated she did not speak with additional residents regarding if they may have had missing items or money. She stated she was not aware of a third shift staff member going through resident belongings and having that information could have been helpful to the facility investigation. The SSD stated the facility's investigation was not thorough and took verbal communication as valid. She stated the purpose of conducting the investigation was an attempt to determine if someone knew something and try to find out what happened. The SSD stated the facility investigation for Resident #2 did not include any statements from direct care staff and did not know if any staff were interviewed in relation to the investigation. She stated more should have been done in both investigations, including talking with staff and other residents.

Interview with the Unit Manager (UM), on 03/29/13 at 8:30 AM, revealed she had been in her role as UM for two (2) weeks. The UM stated she was unaware of Residents' #1 and #2 missing money until a week ago. She stated she was not involved in interviewing staff for facility investigations. She stated no one from the facility interviewed or took her statement for either residents' missing money.

Interview, on 03/29/13 at 10:05 AM, with the interim DON revealed she had been with the

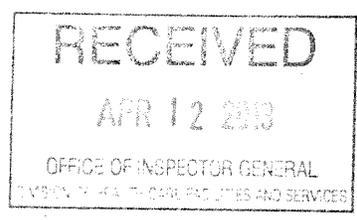
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F 226	<p>Continued From page 6</p> <p>facility three (3) weeks. The DON stated her role in an investigation was to find out who was present at the time of the incident, talk to the resident, ask staff and call staff for statements. She stated she did not call staff for statements for Resident #1 or #2's investigations. She stated she informed staff to give written statements to the SSD. The DON stated the aides assigned to work with Residents #1 and #2 should have been interviewed. She stated she did not read the two (2) statements for Resident #1's investigation and was unaware an aide identified on the previous shift may have been involved in the missing money. The DON stated she should have interviewed the previous shift's aide identified in the statement and was not sure why she had not done so. She stated the UM was responsible to interview staff for Resident #1 and #2's investigations and those statements would then be given to the SSD. The DON stated she did not know which staff members had been interviewed for either investigation for Residents' #1 or #2. She stated she did not review the staff statements prior to their submission to the SSD. She also stated she was not aware if other residents were interviewed. The DON stated staff interviews and the information about a third shift staff member going through resident belongings could have been helpful to the investigation. She stated the facility investigations for Resident #1 and Resident #2 were not as thorough as they should have been. She stated the result of the investigations could be the residents were not cared for as they should.</p> <p>Interview with the Administrator, on 03/29/13 at 10:35 AM, revealed she had been employed at the facility three (3) weeks. She stated the facility</p>	F 226		



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F 226	Continued From page 7 had one phone number for the third shift aide identified in the statement. The Administrator stated she informed the SSD to get statements from staff working for Resident #1's investigation. The Administrator stated she would receive a copy of the facility's investigation; however, she had not read the two (2) employee statements for Resident #1's investigation and was unaware a previous aide had been identified. She stated she did not know if the previous aide had been interviewed. The Administrator stated the facility would need to re-open the investigations for Residents' #1 and #2 as the information regarding a third shift CNA going through resident belongings had not been received. She stated the DON would be responsible to obtain staff statements if nursing was involved in the investigation. She stated the Director of Housekeeping's statement should have specified which staff he had spoken with or had the staff members write their own statements regarding Resident #2's missing money. The Administrator stated she did not know which staff members were interviewed during the two (2) investigations. She stated she had spoken with the SSD throughout the investigations and the SSD was responsible to file the final reports. She stated it was possible if more staff and residents had been interviewed, the facility's investigation could have had more information to help protect resident belongings.	F 226		
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