| DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE & | | | | PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 |
|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUC A. BUILDING B. WING | ΓΙΟΝ | (X3) DATE SURVEY COMPLETED <mark>04/09/2013</mark> |
| | 185337 | | | |
| NAME OF PROVIDER OF SUF | PLIER | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & REH | ABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| For information on the nursing h | nome's plan to correct this deficien | cy, please contact the nursing hor | ne or the state survey agency. | |
| | SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM | | ENCY MUST BE PRECEDED BY | Y FULL REGULATORY |
| F 0157 | notify the attending physician of a #18 had an abnormal Urinalysis (a 4:00 PM; however, there was n On 03/25/13 (a timeframe of three Practitioner reviewed the results of the UA results. The findings includated December 2010) revealed a change in condition evaluation in condition form, if applicable. C message is left with the Physician needed. 5. Document in the medic the facility admitted Resident #18 03/21/13 revealed the physician or eceived the results of the UA, wl 03/22/13. However, there was no was available to receive the fax o medical record all physician contact of the theorem of the theo | om, etc.) that affect the resident I'S HAVE BEEN EDITED TO PEN, and review of the facility's polia change in condition for one of t UA) on 03/22/13. The facility favo o evidence the facility followed to edays after the facility followed to days after the facility followed to days after the facility and the fithe UA while at the facility and the following: 3. If the change in tool. 4. Review all findings with tool. 5. The personnel and a timely real record all Physician contacts a on of/14/11 with [DIAGNOSEs ordered a Urinalysis (UA) for Resnich were abnormal, on 03/22/13. evidence in the medical record the first the UA results, followed up with acts and notifications regarding the states and notifications regarding the following day regarding the abit 20 AM on 04/03/13. According | • | he facility failed to sident #18). Resident physician on 03/22/13 e abnormal UA results. a Nurse lent #18 based on ion policy/procedure e threatening, utilize ractitioner. Fax change ive the fax. If a th another message as edical record revealed sician's telephone order dated urine. The facility cian at 4:00 PM on lax to ensure someone occumented in the An interview was physician on 03/22/13. The staff should have ducted with the Assistant r assessed Resident #18 at the |

F 0157 Immediately tell the resident, the resident's doctor and a family member of the resident

of situations (injury/decline/room, etc.) that affect the resident.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
Based on interview, record review, and review of the facility's policy/procedures it was determined the facility failed to notify the attending physician of a change in condition for one of twenty-nine sampled residents (Resident #18). Resident #18 had an abnormal Urinalysis (UA) on 03/22/13. The facility faxed a copy of the UA results to the physician on 03/22/13 at 4:00 PM; however, there was no evidence the facility followed up with the physician regarding the abnormal UA results. On 03/25/13 (a timeframe of three days after the facility faxed the results of the UA to the physician) a Nurse Practitioner reviewed the results of the UA while at the facility and prescribed an antibiotic for Resident #18 based on the UA results. The findings include: A review of the facility's Change in Condition Action/Notification policy/procedure (dated December 2010) revealed the following: 3. If the change in condition does not appear to be life threatening, utilize a change in condition polypacing in a change in condition physician practitioner. Fax change a change in condition evaluation tool. 4. Review all findings with the Physician and non-physician practitioner. Fax change in condition form, if applicable. Contact the Physician's office to assure someone is available to receive the fax. If a message is left with the Physician's office personnel and a timely response is not given, follow-up with another message as needed. 5. Document in the medical record all Physician contacts and notifications. Review of the medical record revealed the facility admitted Resident #18 on 06/14/11 with [DIAGNOSES REDACTED]. A review of a physician's telephone order dated 03/21/13 revealed the physician ordered a Urinalysis (UA) for Resident #18 due to dark malodorous urine. The facility received the results of the UA, which were abnormal, on 03/22/13, and faxed the results to the physician at 4:00 PM on 03/22/13. However, there was no evidence in the medical record that the facility followed up on the fax to ensure someone 03/22/13. However, there was no evidence in the incurcan record that the racinty followed up on the fax to ensure someone was available to receive the fax of the UA results, followed up with another message as needed, or documented in the medical record all physician contacts and notifications regarding the resident's change in condition. An interview was conducted with Registered Nurse #5 at 5:15 PM on 04/02/13. The RN stated she faxed the UA to the physician on 03/22/13. The RN further stated she did not follow up on the fax and she was off duty the next day. The RN stated staff should have followed up with the physician the following day regarding the abnormal UA. An interview was conducted with the Assistant Director of Nursing (ADON) at 9:20 AM on 04/03/13. According to the ADON, a Nurse Practitioner assessed Resident #18 at the facility during a routine visit on 03/25/13 and determined Resident #18 needed antibiotic therapy due to the abnormal results of the UA. Interview and record review revealed the Nurse Practitioner ordered 50 milligrams (mg) of Nitrofuran

results of the UA. Interview and record review revealed the Nurse Practitioner ordered 50 milligrams (mg) of Nitrofuran (antibiotic) to be administered four times a day, for seven days, for Resident #18 for treatment of [REDACTED].

F 0223

Protect each resident from all abuse, physical punishment, and being separated from

*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policies it was determined the facility based on interview, record review, and review of the facility's investigation and policies it was determined the facility's failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume, According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker and left a voice mail message on the Social Worker and left a voice mail message on the Social Worker and left a voice mail message on the Social Staff Device of Staf Morker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to

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

TITLE

(antibiotic) to be administered four times a day, for seven days, for Resident #18 for treatment of [REDACTED].

(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.

FORM CMS-2567(02-99) Event ID: YL1O11 Previous Versions Obsolete

Facility ID: 185337

If continuation sheet

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
|---|--|--|--|
| NAME OF PROVIDER OF S LEE COUNTY CARE & R | SUPPLIER EHABILITATION CENTER | STREET ADDRESS, CIT 246 EAST MAIN STREE BEATTYVILLE, KY 413 | \mathbf{T} |
| For information on the nursing (X4) ID PREFIX TAG | - | cy, please contact the nursing home or the state survey agency DEFICIENCIES (EACH DEFICIENCY MUST BE PRECED MATION) | |
| F 0223 | (continued from page 1) be in charge of resident care and of Coordinator/Nurse Manager initis Social Worker/Abuse Coordinator direct resident care until 12:30 PM policy revealed the Administrator decisions related to the removal of investigation, the facility determined record review revealed LPN #1 of the control of the coordinate | remained on the floor with residents during the time the Staff sted the investigation, talked with the other staff, and attempt r, Director of Nursing, and Nurse Consultant on what action M, approximately five hours after staff observed the abuse. A r and/or Director of Nursing (DON) and/or Social Worker wa f the alleged abuser from direct care/contact. As a result of the allegation of abuse was unsubstantiated on 02/22/13. id not return to the facility and was terminated from the facility | ed to get direction from the to take. LPN #1 remained in review of the facility's s required to make immediate he facility's however, interview and ty on 02/25/13 related to |
| | falsification of documentation. TI from abuse caused, or was likely including Resident #1. Immediate ongoing. The facility was notified CFR 483.13 Resident Behavior a 01/2012, revealed the facility uph residents. The policy stated that a to the charge nurse and/or Abuse immediate safety and well-being. Director of Nursing and/or Social direct care giving or direct contact revealed the resident was assesses. Further review revealed the facilit assessment performed on Resider if episodes are pain or not as (he/ [REDACTED]. A review of the fiphysician related to the resident's Care dated 02/14/13 revealed the repetitive verbalizations and moan investigation, dated 02/22/13, rev the nurses' station crying and requ #1 (the charge nurse) would not a member reported LPN #1 made a LPN #1 was immediately suspend stated in interview she wanted Re behavior. Documentation in the re had overheard LPN #1 say negati substantiated. LPN #1 say negati resident's consumer to documentation Aide (SRNA) #2, and dated 02/17 nurses' station. The statement furt dining room. I'm leaving (him/he At approximately 10:00 AM, LPP 9:55 AM, 03/02/12 at 10:05 AM, 03/01/13 at 12:29 PM, revealed o SRNA attempted to talk with the wanted to go to bed. While he wa the volume louder on a radio that wheelchair around the corridors of the nurses' station and told the sta Medication Aide (KMA) #1 on 00 ordered, scheduled, [MEDICATI to the resident's complaints of pain. A re RECORD DETAILS REDACTED]. Accord to the nurses' station approximately medication pass and the resident to the resident in a loud voice, you inappropriate and was going to re the nurses' station approximately medication pass and the resident the resident in a loud voice, you inappropriate and was going to re the nurses' station after passing m bed. KMA #1 stated Resident #1. was located. KMA #1 stated Resi want to go to bed. While he wa socated to be dec | to cause, serious injury, harm, impairment, or death to reside to cause, serious injury, harm, impairment, or death to reside to 2 leopardy was identified on 03/01/13 and was determined to 1 of the Immediate Jeopardy on 03/01/13. Substandard Qualit of the Immediate Jeopardy on 03/01/13. Substandard Qualit of the Immediate Jeopardy on 03/01/13. Substandard Qualit of Facility Practices. The findings include: A review of the faolds resident rights and strictly prohibits verbal, sexual, phys my report or suspicion of an incident of abuse was required to Coordinator, as appropriate. The resident was to receive mea following the incident and during the investigation process. To Worker would make any immediate decisions related to the trelated to the alleged or suspected abuse. A review of Read of by the facility to be moderately cognitively impaired, therefy thad assessed the resident to have a history of pain. A review of Readility nurse's notes dated 02/14/13, revealed facility staff had increase in pain and requested new pain medication. A review physician adjusted Resident #1's pain medications due to the ing even after the pain medication had been given. A review caled on the morning of 02/17/13, after the morning meal, steating to go to bed. The investigation revealed staff was intellow staff to put the resident to bed as the resident was crying comment that indicated she was going to teach the resident sed pending the outcome of the investigation. In addition, act set we things about another residents on the unit were interviewed at ventings about another residents on the unit were interviewed are ventings about another residents. The investigation further stager employed by the facility at the time of the investigation. A review of LPN #1's employee file revealed the LPN was tentation. Review of the facility's withers statement signed to the resident and the resident was hollering, SRNA #3 talking to the resident and threesidents and the serious of the resident and the resident was huffly and the resident and | ure residents were free ints in the facility exist on 02/17/13, and is y of Care was identified at 42 icility's abuse policy, dated ical, and mental abuse of the perported immediately sures to ensure his or her The Administrator and/or removal of individuals from lent #1's medical record fore, non-interviewable. We of a facility pain petitive verbalizations unsure sident #1's physician's orders ident #1's physician's orders ident #1's physician's orders ident #1's physician's orders ident #1's continued of the facility's and observed Resident #1 at reviewed and reported LPN grand yelling. One staff ideas on, Further review revealed for of the facility on the report, LPN #1 or monitor the resident's ideas on, Further review revealed for of the report, LPN #1 or monitor the resident's idea duse could not be attempts to contact LPN #1 miniated from the facility on by State Registered Nurse of leave Resident #1 at the sean for hollering in the enurses' station at the time. An attempt was made on 03/01/13 at 2ess. An interview with SRNA #3 on Resident #1 was hollering and the that he/she was hurting and the resident #1 was hollering and the that he/she was hurting and the that he/she was hurting and the hurting and the resident #1 to begin a ted she heard LPN #1 tell had the LPN's remark was so the heard LPN #1 tell had the resident would sit up until to have the had a comment that Resident #1 was Resident #1 would usually cry after 1. The housekeeper's #1 to be loud and used a tone that 7/13, LPN #1 was more than just Resident #1 to the nurses' of Housekeeper's #1's 13 Resident #1 to the order with that tat |
| | Coordinator/Nurse Manager, the | staff stated they were uncomfortable with the tone LPN #1 us | sed with Resident #1. The Staff |

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 2)
Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the cititiy's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager intitated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATTE] and attempted to interview Resident #1; however, she was unable to get an adequate interview development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated one resident stated to abuse. While interview Resident #1; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 and 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and F 0223 F 0223 Protect each resident from all abuse, physical punishment, and being separated from **NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on interview, record review, and review of the facility's investigation and policies it was determined the facility failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident allow staft to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing, and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM approximately five hours after staff observed the abuse. A review of the facility's direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. A review of the facility's policy revealed the Administrator and/or Director of Nursing (DON) and/or Social Worker was required to make immediate decisions related to the removal of the alleged abuser from direct care/contact. As a result of the facility's investigation, the facility determined the allegation of abuse was unsubstantiated on 02/22/13. However, interview and investigation, in facting occurring the largest of a date, was unsubstantiated on 22.15.1 moved, into the waste record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. The facility's failure to have an effective system in place to ensure residents were free falsification of documentation. The facility's failure to have an effective system in place to ensure residents were free from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility including Resident #1. Immediate Jeopardy was identified on 03/01/13 and was determined to exist on 02/17/13, and is ongoing. The facility was notified of the Immediate Jeopardy on 03/01/13. Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices. The findings include: A review of the facility's abuse policy, dated 01/2012, revealed the facility upholds resident rights and strictly prohibits verbal, sexual, physical, and mental abuse of residents. The policy stated that any report or suspicion of an incident of abuse was required to be reported immediately to the charge nurse and/or Abuse Coordinator, as appropriate. The resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. A review of Resident #1's medical record revealed the resident was assessed by the facility to be moderately cognitively immired therefore, non-interviewable direct care giving or direct contact related to the alleged or suspected abuse. A review of Resident #1's medical record revealed the resident was assessed by the facility to be moderately cognitively impaired, therefore, non-interviewable. Further review revealed the facility had assessed the resident to have a history of pain. A review of a facility pain assessment performed on Resident #1, dated 02/04/13, revealed the resident had episodes of repetitive verbalizations unsure if episodes are pain or not as (he/she) has some actions were pain meds given. A review of Resident #1's physician's orders [REDACTED]. A review of the facility nurse's notes dated 02/14/13, revealed facility staff had contacted the resident's physician related to the resident's increase in pain and requested new pain medication. A review of Resident #1's Plan of Care dated 02/14/13 revealed the physician adjusted Resident #1's pain medications due to the resident's continued repetitive verbalizations and moaning even after the pain medication had been given. A review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying and requesting to go to bed. The investigation revealed staff was interviewed and reported LPN #1 (the charge nurse) would not allow staff to put the resident to bed as the resident was crying and yelling. One staff member reported LPN #1 made a comment that indicated she was going to teach the resident a lesson. Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. In addition, according to the report, LPN #1 stated in interview she wanted Resident #1 to stay at the nurses' station in order for the nurse to monitor the resident's behavior. Documentation in the report revealed other residents on the unit were interviewed and one resident stated he/she had overheard LPN #1 say negative things about another resident. The investigation further stated abuse could not be behavior. Documentation in the report revealed other residents on the unit were interviewed and one resident stated he/she had overheard LPN #1 say negative things about another resident. The investigation further stated abuse could not be substantiated. LPN #1 was no longer employed by the facility at the time of the investigation. Attempts to contact LPN #1 for interview were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from the facility on 02/25/13 for falsification of documentation. Review of the facility's witness statement signed by State Registered Nurse Aide (SRNA) #2, and dated 02/17/13, revealed on 02/17/13 after breakfast LPN #1 told staff to leave Resident #1 at the nurses' station. The statement further revealed LPN #1 stated, I'm going to teach (him/her) a lesson for hollering in the dining room. I'm leaving (him/her) up for a while. SRNA #2 reported music was playing at the nurses' station at the time. At approximately 10:00 AM, LPN #1 informed staff they could lay Resident #1 down in bed. An attempt was made on 03/01/13 at 9:55 AM, 03/02/12 at 10:05 AM, and 03/03/13 at 5:05 PM to interview SRNA #2 with no success. An interview with SRNA #3 on 03/01/13 at 12:29 PM, revealed on the morning of 02/17/13, between 9:00 AM and 9:30 AM, Resident #1 was hollering and the SRNA attempted to talk with the resident. According to interview, the resident told SRNA #3 that he/she was hurting and wanted to go to bed. While he was talking to the resident and the resident was hollering, SRNA #3 stated LPN #1 turned up the volume louder on a radio that was playing music at the nurses' station. SRNA #3 stated he wheeled Resident #1 in the wheelchair around the corridors of the building for approximately 10 to 15 minutes and then brought the resident back to the nurses' station and told the staff the resident was hurting and had requested to go to bed. An interview with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM revealed on the morning of 02/17/13 she had administere

resident's complaints of pain. A review of Resident #1's Medication Administration Record [MEDICATION ADMINISTRATION RECORD

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION (continued... from page 3) DETAILS REDACTED]. According to KMA #1, Resident #1 had told LPN #1 that he/she was in pain. KMA #1 stated she returned F 0223 the nurses' station approximately 30 to 45 minutes after she administered the pain medication to Resident #1 to begin a medication pass and the resident was still sitting in the chair at the nurses' station. KMA #1 stated she heard LPN #1 tell the resident in a loud voice, You can't lay down till you stop crying. KMA #1 stated she thought the LPN's remark was inappropriate and was going to report the LPN after she had completed the medication pass; however, when she returned to the nurses' station after passing medications, Resident #1 was no longer sitting at the nurses' station and was lying in bed. KMA #1 stated Resident #1 could tell staff when he/she was hurting and in pain but could not tell staff where the pain was located. KMA #1 stated Resident #1 often experienced increased pain when sitting up in a chair and staff usually assisted the resident to bed after breakfast due to the resident's complaints of increased pain. The interview further revealed KMA #1 thought LPN #1's actions toward Resident #1 were abusive. A review of KMA 1's witness statement, signed and dated 02/17/13 by KMA #1, revealed on 02/17/13 she witnessed LPN #1 tell Resident #1 that the resident would sit up until (he/she) stopped crying, and then the LPN turned up the volume of the radio at the nurses' station. Interview with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM revealed Resident #1 would usually cry after breakfast in the morning of 02/17/13 at approximately 7:35 AM, LPN #1 made a comment that Resident #1 was not going to bed because the resident was whining and crying. According to Housekeeper #1, Resident #1 repeatedly said, I want to go to bed, I'm hurting, take me to bed. Housekeeper #1 stated LPN #1 had a tendency to be loud and used a tone that was a combination of hateful and rude. According to Housekeeper #1 memoring of 02/17/13. LPN #1 was more than just loud and was verbally abusive to Resident #1. Housekeeper #1 further stated LPN #1 wheeled Resident #1 to the nurses' station, placed a the nurses' station approximately 30 to 45 minutes after she administered the pain medication to Resident #1 to begin a wanting to go to bed. LPN #1 told Resident #1 that as long as (he/she) whined and cried, the resident was not going to bed. Further review of the witness statement revealed staff attempted to take the resident to bed and LPN #1 told staff no. The witness statement went on to say LPN #1 obtained a radio, placed it at the nurses' station, and turned it up to drown out Resident #1 crying. Interview with Housekeeper #2 on 03/01/13 at 11:47 AM revealed on the morning of 02/17/13 LPN #1 would not allow facility staff to assist Resident #1 to bed. According to Housekeeper #2, Resident #1 did cry and holler that he/she was in pain and wanted to go to bed. However, according to the housekeeper , LPN #1 stated to the resident that he/she had to sit in front of the desk until the resident quit hollering. Housekeeper #2 further stated LPN #1 obtained a radio, placed it at the nurses' station near the resident's head, and turned the volume up real loud. Further interview revealed she and other staff who had witnessed the incident discussed the incident and felt the incident needed to be reported. Housekeeper #2 stated she and another housekeeper attempted to contact the Social Worker/Abuse Coordinator to report the allegation, but the Social Worker/Abuse Coordinator did not answer the phone and she left a voice message report the anegation, but the Social Worker/Abuse Coolumnator during answer the pinter and since that social was regarding the incident. In addition, a review of the facility's witness statement signed by Housekeeper #2 and dated 02/17/13 revealed LPN #1 was talking to Resident #1 in a way she shouldn't haven't. The witness statement further stated Resident #1 was crying in the dining room at breakfast, and LPN #1 refused to let staff put the resident to bed. According to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up at the nurses' station and turned it up really loud because the resident #1 to the lineses station, obtained a radio, and set rup at the nurses' station and turned it up really loud because the resident was crying. Interview with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and as she was coming out of her office between 11:30 AM and 11:40 AM, Housekeepers #1 and #2 met her in the hall to inform her they felt uneasy about an incident they had witnessed. According to the Staff Development Coordinator/Nurse Manager, the staff stated they were uncomfortable with the tone LPN #1 used with Resident #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the facility's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the was advised to obtain a whiten statement from LPTN #1 and then to imform the LPTN sie was being sein noise pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a second voice mail message from the housekeepers at the facility and a second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; however, she was worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; nowever, she unable to get an adequate interview due to the resident's cognition level. The Social Worker/Abuse Coordinator stated her part of the investigation was to interview residents related to abuse. While interviewing residents on that day, the Social Worker/Abuse Coordinator stated one resident did report he/she had heard LPN #1 being rude to another resident; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and information that had been obtained, consulted with his regional staff, conducted three or four interviews for follow-up, and re-interviewed LPN #1 to ensure accuracy. According to Administrator #1, LPN #1 admitted Resident #1 was crying and yelling at the nurses' station and the LPN did ask staff to leave the resident up in the chair. According to Administrator #1, LPN #1 told him she wanted to observe the resident to see if the resident was in pain. Administrator #1 acknowledged during interviews he conducted, one SRNA reported LPN #1 stated that she was going to teach a lesson and make the resident to the out-the very the pursue of the state of the this investigation and was up of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the state of the triangle interview and regions of the state of the stay out there at the nurses' station. Administrator #1 stated after the investigation, interview, and review of the witness statements he felt like he could not come to a firm conclusion to substantiate abuse. He further stated the facility unsubstantiated abuse because staff may have misinterpreted LPN #1's actions. F 0223 Protect each resident from all abuse, physical punishment, and being separated from others.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY others.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, and review of the facility's investigation and policies it was determined the facility failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing, and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. A review of the facility's policy revealed the Administrator and/or Director of Nursing (DON) and/or Social Worker was required to make immediate decisions related to the removal of the alleged abuser from direct care/contact. As a result of the facility's investigation, the facility determined the allegation of

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 4 of 59 Previous Versions Obsolete

| | TH AND HUMAN SERVICES E & MEDICAID SERVICES | | | PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 |
|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUC A. BUILDING B. WING | TION | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF S LEE COUNTY CARE & R | SUPPLIER EHABILITATION CENTER | | STREET ADDRESS, CITY, ST. 246 EAST MAIN STREET | ATE, ZIP |
| For information on the nursing | ng home's plan to correct this deficien | cy, please contact the nursing hor | me or the state survey agency. | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | | ENCY MUST BE PRECEDED B | Y FULL REGULATORY |
| F 0223 | CFR 483.13 Resident Behavior a 01/2012, revealed the facility up residents. The policy stated that a to the charge nurse and/or Abuse immediate safety and well-being Director of Nursing and/or Socia direct care giving or direct contact revealed the resident was assess Further review revealed the facility assessment performed on Resider if episodes are pain or not as (he/ IREDACTED). A review of the f physician related to the resident's Care dated 02/14/13 revealed the repetitive verbalizations and moa investigation, dated 02/22/13, reventen urses' station crying and req. #1 (the charge nurse) would not a member reported LPN #1 made at LPN #1 was immediately suspenstated in interview she wanted Rebehavior. Documentation in the rehad overheard LPN #1 say negative substantiated. LPN #1 was no lor for interview were unsuccessful. 02/25/13 for falsification of docu Aide (SRNA) #2, and dated 02/1 nurses' station. The statement fur dining room. I'm leaving (him/he At approximately 10:00 AM, LP) 9:55 AM, 03/02/12 at 10:05 AM, 03/01/13 at 12:29 PM, revealed c SRNA attempted to talk with the wanted to go to bed. While he was the volume louder on a radio that wheelchair around the corridors of the nurses' station and told the stamedication Aide (KMA) #1 on 0 ordered, scheduled, [MEDICATI to the resident's complaints of pain. A record to the nurses' station approximately medication pass and the resident the resident in a loud voice, You inappropriate and was going to rethe nurses' station after passing in bed. KMA #1 stated Resident #1 was located. KMA #1 stated Resident #1 was located. KMA #1 stated Resident #1 was located. KMA #1 thought LPN # dated 02/17/13 by KMA #1, reve (he/she) stopped crying, and then Housekeeper #1 on 02/28/13 at 1 breakfast in the mornings, would that following breakfast on the mot going to bed because the resident for brown as a combination of hateful and loud and was verbally abusive to station, placed a radio near Resid written statement signed and date wanting to go to bed. LPN #1 to breakfas | and Facility Practices. The finding olds resident rights and strictly prony report or suspicion of an incident was propriate. The following the incident and during I Worker would make any immed to related to the alleged or suspect d by the facility to be moderately try had assessed the resident to hant #1, dated 02/04/13, revealed the she) has some actions were pain 1 racility nurse's notes dated 02/14/2 increase in pain and requested ne physician adjusted Resident #1's uning even after the pain medicative aled on the morning of 02/17/13 uesting to go to bed. The investig allow staff to put the resident to be a comment that indicated she was ded pending the outcome of the inseident #1 to stay at the nurses' streport revealed other residents on the things about another resident. Germent and the resident for the revealed of 02/17/13 after the pain and 03/03/13 at 5:05 PM to interior the morning of 02/17/13, attention. Review of the facility at the revealed of 02/17/13 after the revealed LPN #1 stated, I'm; and 03/03/13 at 5:05 PM to interior the morning of 02/17/13, between the morning of 02/17/13 after the revealed LPN #1 stated, I'm; and 03/03/13 at 5:05 PM to interior the morning of 02/17/13, between the morning of 02/17/13, between the morning of 02/17/13 at 12/17/13 the provident #1 bad 30 to 45 minutes after she admin was still sitting in the chair at the can't lay down till you stop crying both the LPN #1 the chair at the can't lay down till you stop crying both the LPN turned up the volume of 12/17/13 at 12/17/13 are she had complexity and the stay of the sident #1 bad 30 to 45 minutes after she admin was still sitting in the chair at the can't lay down till you stop crying both the LPN turned up the volume of 12/17/13 are valided the follow the facility's with the stay of the facility's with the stay of the facility's with the stay of the fac | 3/01/13. Substandard Quality of Cs include: A review of the facility robibits verbal, sexual, physical, a ent of abuse was required to be resident was to receive measures; the investigation process. The Actiate decisions related to the removed abuse. A review of Resident # cognitively impaired, therefore, note a history of pain. A review of a resident had episodes of repetitimeds given. A review of Resident 13, revealed facility staff had contempain medications. A review of F pain medications due to the reside on had been given. A review of the pain medication and review of the safter the morning meal, staff obstation revealed staff was crying and going to teach the resident a lesson vestigation. In addition, accordination in order for the nurse to monthe unit were interviewed and one The investigation. In addition, accordination in order for the nurse to monthe unit were interviewed and one The investigation. Attermile revealed the LPN was termina so witness statement signed by Starvestigation to teach (him/her) a lesson feed music was playing at the nurse y Resident #1 down in bed. An artive 950 AM #2 with 30 AM, #3 that he sident was hollering, SRNA #3 station. SRNA #3 station. SRNA #3 station. SRNA #3 station. SRNA #3 station of SRNA #3 that he sident was hollering, SRNA #3 station. SRNA #3 stated he wheel 10 to 15 minutes and the brough ad requested to go to bed. An inter the morning of 02/17/13 she had incompleted the pain medication to Res nurses' station. KMA #1 stated she thought the medication pass; however one sitting at the nurses' station in a diministration Record [MEDICATION NAME]) to Resident #1 that he resident was review of KMA 15 pN #1 tell Resident #1 that the resident pain when sitting up in a chair plaints of increased pain. The interent because of the resident pass; however one sitting at the nurses' station. In the pain when sitting up in a chair plaints of increased pain. The interest business of the pain was reviewed the state of the pain was reviewed the pain was reviewed to the remai | s abuse policy, dated nd mental abuse of ported immediately to ensure his or her Iministrator and/or val of individuals from l's medical record on-interviewable. If acility pain we verbalizations unsure #1's physician's orders acted the resident's desident #1's Plan of ent's continued e facility's served Resident #1 at ed and reported LPN yelling. One staff in. Further review revealed go the report, LPN #1 itor the resident's resident stated he/she buse could not be pts to contact LPN #1 ted from the facility on the Registered Nurse e Resident #1 at the for hollering in the set station at the time. empt was made on 03/01/13 at An interview with SRNA #3 on ent #1 was hollering and the set she with Kentucky administered a physician et at approximately 8:30 AM due ATION ADMINISTRATION win. KMA #1 stated she returned ident #1 to begin a to heard LPN #1 tell LPN's remark was r, when she returned to and was lying in ell staff where the pain and staff usually erview further is witness statement, signed and sident would sit up until terview with would usually cry after housekeeper stated ment that Resident #1 was ent #1 repeatedly said, I oud and used a tone that LPN #1 was more than just ent #1 to the nurses' usekeeper's #1's sident #1 was roying and twas not going to bed. #11 told staff no. The if up to drown out not go 10/17/13 LPN #1 would you foll of 17/17 yell of your poll your poll of yo |

PRINTED:3/30/2014

| CENTERS FOR MEDICARE | & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTA. BUILDING B. WING | ΓΙΟΝ | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SU LEE COUNTY CARE & REF | | | STREET ADDRESS, CITY, STA 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | ATE, ZIP |
| | home's plan to correct this deficient | | , , , | V FULL DECLU A TODA |
| (X4) ID PREFIX TAG | OR LSC IDENTIFYING INFOR | | ENCY MUST BE PRECEDED BY | Y FULL REGULATORY |
| F 0223 | Worker/Abuse Coordinator stated unable to get an adequate intervit part of the investigation was to in Worker/Abuse Coordinator stated the resident was unsure if LPN # Administrator #1 on 02/28/13 at information that had been obtain and re-interviewed LPN #1 to en yelling at the nurses' station and if #1, LPN #1 told him she wanted during interviews he conducted, stay out there at the nurses' station. | d she went to the facility on [DAT] we due to the resident's cognition sterview residents related to abuse d one resident did report he/she ha 1 was talking to the resident or ab 5:20 PM revealed during the inve- ed, consulted with his regional sta sure accuracy. According to Adm the LPN did ask staff to leave the to observe the resident to see if th one SRNA reported LPN #1 state on. Administrator #1 stated after th | or/Nurse Manager. After she recei Te] and attempted to interview Reselevel. The Social Worker/Abuse Co. While interviewing residents on ad heard LPN #1 being rude to and out the resident at the time. Intervising time to the reviewed the witness off, conducted three or four intervisinistrator #1, LPN #1 admitted Reresident up in the chair. According the resident was in pain. Administrated that she was going to teach a less the investigation, interview, and review to substantiate abuse. He furth | sident #1; however, she was Coordinator stated her that day, the Social ther resident; however, iew with statements and ews for follow-up, sident #1 was crying and g to Administrator ttor #1 acknowledged son and make the resident riew of the |
| F 0223 | witness statements he felt like he facility unsubstantiated abuse ber Protect each resident from all a others. ***NOTE- TERMS IN BRACKE* Based on interview, record revier failed to have an effective system abuse. On 02/17/13 at approxima next to the nurses' station, crying allow staff to take Resident #1 to quit crying, hollering, and/or whit to interviews, staff attempted to 1 facility policy; however, staff wa Worker's telephone. Staff reporte at approximately 11:40 AM, app be in charge of resident care and Coordinator/Nurse Manager initi Social Worker/Abuse Coordinate direct resident care until 12:30 PJ policy revealed the Administrato decisions related to the removal investigation, the facility determirecord review revealed LPN #1 dfalsification of documentation. T from abuse caused, or was likely including Resident #1. Immediatongoing. The facility was notified CFR 483.13 Resident Behavior a 01/2012, revealed the facility up residents. The policy stated that a to the charge nurse and/or Abuse immediate safety and well-being Director of Nursing and/or Socia direct care giving or direct contact care direct care giving or direct contact care direct care giving or direct contact care giving and giving and giving an | could not come to a firm conclus cause staff may have misinterprete buse, physical punishment, and IS HAVE BEEN EDITED TO PF, w, and review of the facility's invet in place to ensure one of twenty-tely 7:35 AM, staff observed Res in pain, and requesting to go to be deand stated the resident would ming. LPN #1 placed a radio near eport the alleged abuse to the Soc is unable to contact the Social Wood the allegation of abuse to the Stroximately four hours after staff or remained on the floor with reside ated the investigation, talked with or, Director of Nursing, and Nurse M, approximately five hours after and/or Director of Nursing (DOI of the allegad abuser from direct cand the allegation of abuse was used to the allegation of abuse was used to the allegation of abuse was used to cause, serious injury, harm, ime leopardy was identified on 03/0 dof the Immediate Jeopardy on 0. In Facility Practices. The finding holds resident rights and strictly pury report or suspicion of an incid Coordinator, as appropriate. The following the incident and during I Worker would make any immed et related to the alleged or suspect do by the facility to be moderately thy had assessed the resident to han time, and the subject of the subj | ion to substantiate abuse. He furth ed LPN #1's actions. | er stated the mined the facility #1) was free from tated in the dining room (1) #1 refused to mittl the resident the volume. According accordance with on the Social see Manager on 02/17/13, taled LPN #1 continued to lopment tet direction from the . LPN #1 remained in v of the facility's irred to make immediate lity's ver, interview and 02/25/13 related to sidents were free the facility to 02/17/13, and is are was identified at 42 s abuse policy, dated and mental abuse of ported immediatelly to ensure his or her liministrator and/or al of individuals from 's medical record on-interviewable. facility pain to verbalizations unsure #1's physician's orders acted the resident's esident #1's Plan of mit's continued to facility's erved Resident #1 at de and reported LPN velling. One staff n. Further review revealed g to the report, LPN #1 tor the resident's resident stated he/she use could not be puts to contact LPN #1 ed from the facility on to Registered Nurse to Resident #1 at the or hollering in the se's station at the time. The province of the province of the province the resident #1 at the or hollering in the se's station at the time. The province of the province of the province the resident #1 at the or hollering and the self-she was hurting and tated LPN #1 turned up the de Resident #1 in the the resident back to view with Kentucky diministered a physician and at at approximately 8:30 AM du the ATION ADMINISTRATION thin. KMA #1 stated she returned to the returned to und was lying in the latelf was hollering and and LPN #1 tell LPN's remark was r, when she returned to und was lying in ell staff where the pain and staff usually |

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 185337

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

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION) CLIA IDENNTIFICATION À. BUILDING B. WING ____ 04/09/2013 NUMBER 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0223 (continued... from page 6) (he/she) stopped crying, and then the LPN turned up the volume of the radio at the nurses' station. Interview with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM revealed Resident #1 would usually cry after breakfast in the mornings, would request to go to bed, and staff would assist the resident to bed. The housekeeper stated that following breakfast on the morning of 02/17/13 at approximately 7:35 AM, LPN #1 made a comment that Resident #1 was not going to bed because the resident was whining and crying. According to Housekeeper #1, Resident #1 repeatedly said, I want to go to bed, I'm hurting, take me to bed. Housekeeper #1 stated LPN #1 had a tendency to be loud and used a tone that was a combination of hateful and rude. According to Housekeeper #1, on the morning of 02/17/13, LPN #1 was more than just loud and was verbally abusive to Resident #1. Housekeeper #1 further stated LPN #1 wheeled Resident #1 to the nurses' station, placed a radio near Resident #1's head, and turned up the volume of the radio. Review of Housekeeper's #1's station, placed a radio near Resident #1's head, and turned up the volume of the radio. Review of Housekeeper's #1's written statement signed and dated 02/17/13 revealed after breakfast on the morning of 02/17/13 Resident #1 was crying and wanting to go to bed. LPN #1 told Resident #1 that as long as (he/she) whined and cried, the resident was not going to bed. Further review of the witness statement revealed staff attempted to take the resident to bed and LPN #1 told staff no. The witness statement went on to say LPN #1 obtained a radio, placed it at the nurses' station, and turned it up to drown out Resident #1 crying. Interview with Housekeeper #2 on 03/01/13 at 11:47 AM revealed on the morning of 02/17/13 LPN #1 would not allow facility staff to assist Resident #1 to bed. According to Housekeeper #2, Resident #1 did cry and holler that he/she was in pain and wanted to go to bed. However, according to the housekeeper, LPN #1 stated to the resident that he/she had to sit in front of the desk until the resident quit hollering. Housekeeper #2 further stated LPN #1 obtained a radio, placed it at the nurses' station near the resident's head, and turned the volume up real loud. Further interview revealed she and other staff who had witnessed the incident and felt the incident needed to be reported. Housekeeper #2 stated she and another housekeeper attempted to contact the Social Worker/Abuse Coordinator to report the allegation, but the Social Worker/Abuse Coordinator did not answer the phone and she left a voice message report the anegation, but the Social Worker/Abuse Coordinator and not answer the pnohe and she left a voice message regarding the incident. In addition, a review of the facility's witness statement signed by Housekeeper #2 and dated 02/17/13 revealed LPN #1 was talking to Resident #1 in a way she shouldn't haven't. The witness statement further stated Resident #1 was crying in the dining room at breakfast, and LPN #1 refused to let staff put the resident to bed. According to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up at the nurses' station and turned it up really loud because the resident was crying. Interview with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and as she was coming out of her office between 11:30 AM and 11:40 AM, Housekeepers #1 and #2 met her in the hall to inform her they felt uneasy about an incident they had witnessed. According to the Staff Development Coordinator/Nurse Manager, the staff stated they were uncomfortable with the tone LPN #1 used with Resident #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the facility's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; however, she was unable to get an adequate interview due to the resident's cognition level. The Social Worker/Abuse Coordinator stated her part of the investigation was to interview residents related to abuse. While interviewing residents on that day, the Social Worker/Abuse Coordinator stated one resident did report he/she had heard LPN #1 being rude to another resident; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and information that had been obtained, consulted with his regional staff, conducted three or four interviews for follow-up, and re-interviewed LPN #1 to ensure accuracy. According to Administrator #1, LPN #1 admitted Resident #1 was crying and yelling at the nurses' station and the LPN did ask staff to leave the resident up in the chair. According to Administrator #1, LPN #1 told him she wanted to observe the resident to see if the resident was in pain. Administrator #1 acknowledged during interviews he conducted, one SRNA reported LPN #1 stated that she was going to teach a lesson and make the resident stay out there at the nurses' station. Administrator #1 stated after the investigation, interview, and review of the witness statements he felt like he could not come to a firm conclusion to substantiate abuse. He further stated the facility unsubstantiated abuse because staff may have misinterpreted LPN #1's actions. F 0225 1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect of mistreatment of residents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately to the Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged violations were thoroughly investigated for six of twenty-nine sampled residents (Resident #1, #4, #19, #29, #30, and #31). On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the Nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator of abuse to the Staff Development Coordinator/Nurse Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing (DON), and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. According to the facility investigation, dated 02/22/13, after the investigation was completed the facility unsubstantiated that abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on the morning of 03/24/13, at approximately 12:00 AM, Resident #4 reported to Registered Nurse (RN) #8 that RN #8 was mean to the resident; that the resident did not want RN #8 to provide care for the resident anymore; and, asked RN #8 to not come back into the resident's room. RN #8 documented the incident in Resident #4's medical record and reported the incident to the oncoming Nurse (RN #4) at 7:00 AM, RN #4 reported the incident to the Weekend Manager on 03/24/13, and the Weekend Manager contacted the DON to report the incident. However, the DON did not initiate an investigation of the incident and did not notify the Administrator of the incident, On 03/27/13, the facility's Cooperate Nurse Consultant learned of the incident through review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the start of her shift on 03/27/13. However, the DON and Administrator #2 interviewed RN #8 to continue to provide direct care to residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility failed to ensure four (4) other potential allegations of abuse were thoroughly inv

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet Previous Versions Obsolete Page 7 of 59

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

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED |
|--------------------------------|---|--|--|
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | B. WING | 04/09/2013 |
| NAME OF PROVIDER OF S | UPPLIER | STREET ADD | PRESS, CITY, STATE, ZIP |
| LEE COUNTY CARE & R | EHABILITATION CENTER | 246 EAST MA BEATTYVILI | |
| For information on the nursing | ng home's plan to correct this deficien | cy, please contact the nursing home or the state st | urvey agency. |
| (X4) ID PREFIX TAG | | DEFICIENCIES (EACH DEFICIENCY MUST B MATION) | E PRECEDED BY FULL REGULATORY |
| For information on the nursing | g home's plan to correct this deficient SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM (continued from page 7) reported to the appropriate State A State Registered Nurse Aide (SRI his/her neck; and, Resident #31 bimmediately report an allegation ifailure to thoroughly investigate a or death to residents in the facility abuse. The Immediate Jeopardy v 483.13 Resident Behavior and Fa 03/29/13 and was informed on 04 Allegation of Compliance (AOC) State Survey Agency (SSA) verif with remaining noncompliance at develops and implements a Plan o activities. The findings include: 1 the facility to immediately report of resident's property or reasonab incident was to be reported imme Coordinator, as appropriate, were revealed any report or suspicion of Coordinator, as appropriate. The alleged incidents of abuse involvi incident; the Administrator/designoncerns, and grievances presente safety and wellbeing following th Administrator and/or DON and/o direct care giving or direct contact investigation, dated 02/22/13, and AM, with Housekeeper #2 on 03/ (KMA) #1 on 03/01/13 at 12:01 PM, and #1 was observed to abuse Residen protect residents in the facility or #1 attempted to notify the Social to reach her, and left a message d immediately report the abuse due by the Charge Nurse. Housekeepe Staff Development Coordinator/Nurse Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to remove unterestigation. According to the Sc the Abuse Coordinator (herself), detailed reporting procedure such the Staff Dev | BEATTYVIL. Ey, please contact the nursing home or the state so BETICIENCIES (EACH DEFICIENCY MUST BETICIENCIES) (EACH DEFICIENCY MUST BETICIENCY) MATION) AND #14: Resident #30 being sprayed with cold weing handled roughly by staff while being placed of abuse, failure to protect residents during the contact of abuse, failure to protect residents during the contact of abuse assets, or was likely to care. Immediate Jeopardy situations were identified viril Substandard Quality of Care was determined cility. Practices. The facility was notified of the Ir 109/13 the Immediate Jeopardy was ongoing. The one of 11/13 with the facility alleging removal of ider removal of the Immediate Jeopardy on 04/22. 42 CFR 483.13 Resident Behavior and Facility of Correction and monitors the effectiveness of sy. Review of the facility's abuse policy, dater of 11/14 with the facility alleging removal of ideal the facility investigate allegations of mistrea le suspicion of criminal act or intent. The policy idiately to the charge nurse, and the Administration to be notified immediately by the charge nurse were an incident of abuse was to be immediately repolicy also revealed a thorough investigation was not staff members, residents, family, and/or visito new would make all reasonable efforts to investigate the would make all reasonable efforts to investigate the would make all reasonable efforts to investigate the work of the minute of the property of the property of the work of the property of the p | LE, KY 41311 urvey agency. BE PRECEDED BY FULL REGULATORY at #19; Resident #29 expressing fear of vater and having a towel wrapped around in a chair. The facility's failure to outse of an investigation of abuse, and use, serious injury, harm, impairment, on 03/01/13 and 03/24/13 related to the exist on 02/17/13 and is ongoing at 42 CFR mmediate leopardy on 03/01/13 and e facility provided an acceptable credible full the provided an acceptable and colory on 04/17/13. The 04/23/13, as alleged in the acceptable AOC, Practices F225- S/S E, while the facility stemic changes and quality assurance 2012, revealed it was the intent of timent, neglect, abuse, misappropriation stated any report or suspicion of an r, Director of Nursing and Abuse who receives the report. Further review orted to the charge nurse and/or Abuse to be initiated immediately for all ross who had potential knowledge of the ate and address alleged reports, easurers to ensure his or her immediate The policy further stated the sion related to the removal of individuals from lon a review of the facility's 12:17 PM and again on 03/04/13 at 11:37 at 12:29 PM, with Kentucky Medication Aide A #2 (unable to be reached for interview), LPN to by the staff who witnessed the abuse to immelty 11:30 AM, when Housekeeper silitity's policy, via phone, but was unable 11 and Housekeeper #2 stated they did not to do, since the abuse had been committed her Abuse Coordinator, she observed the had witnessed to her. An interview the had witnessed to her. An interview the had witnessed to her. An interview for the reached by Housekeepers #1 and #2 at ent #1 and LPN #1. The Staff remove LPN #1 (Charge Nurse) from patient or of Nursing had that authority. The Staff remove LPN #1 (Charge Nurse) from patient or for Nursing had that authority. The Staff remove LPN #1 (Charge Nurse) from patient or for sident care and remained on the floor Staff Development Coordinator/Nurse do to suspend LPN #1, the Charge Nurse, sto ensure his or her immediate safety we with the Social Wor |
| | | her on 03/01/13 that SRNA #14 had touched the #14's action was abuse, the resident felt the his a | |

Facility ID: 185337

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | | PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 |
|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCT A. BUILDING B. WING | ΓΙΟΝ | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF SU LEE COUNTY CARE & REF | PPLIER | | STREET ADDRESS, CITY, STA 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | ATE, ZIP |
| For information on the nursing | home's plan to correct this deficience | cv. please contact the nursing hon | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM | DEFICIENCIES (EACH DEFICIE | | Y FULL REGULATORY |
| F 0225 | 04/05/13, at 6:05 PM, with the VI Administrator. The Vice Presiden would attempt to locate the facilit at 7:30 PM revealed SRNA #14 hthe incident to the surveyor. Accomisted of the interviews that he stated effective 04/05/13 SRNA #Vice President of Operations state the facility to work due to a reside President of Operations stated he resident's concern. 3. A review of repeatedly sprayed cold water on following the shower on 03/22/13 investigation was started on 03/22/13 investigation was started on 03/22/policy on abuse revealed a thorou involving staff members, resident on 04/09/13 revealed the facility appropriate State Agencies until (was no evidence the alleged perpy Administrator/designee would ma grievances presented to them; and wellbeing following the incident adated 04/09/13, revealed that SRN be suspended and not allowed to facility's investigation log revealed Worker/Abuse Coordinator on 04 Administrator and the Director of investigation of the allegation of Worker/Abuse Coordinator it wa Administrator #2 on 04/09/13 at with Resident #30 on 03/24/13, haver of the allegation of abuse hwas found on 04/08/13. 4. Interviallegation of abuse that he planne occurred on 03/24/13, was reported. | agencies, and to provide administ 29 that SRNA #14 would be reass 1 she obtained verbal statements fiff Nurse that had been assigned to se Coordinator stated as a result of acility and was permitted to continuous stated she had not considere tion; and did not report the incide wealed a thorough investigation vinembers, residents, family, and/d make all reasonable efforts to in 1 that the resident was to receive 1 and during the investigation processes investigations, she was response staff the results of her investigation for Operations stated although her by sinvestigation. Continued internated continued to work at the facility and led the did recall the resident of Operations reveal at of Operations stated although her by sinvestigation. Continued internate continued to work at the facility and the did recall Administrator #1 ent telling staff he/she did not war could not recall the resident's nanota a facility's investigation revealed the resident during a shower and 8 from 8:00 PM to 9:00 PM. Acced #13 by the facility's Social Workingh investigation was to be with the facility and for was to be subject to the state of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to receive 1 and during the investigation process of the sident was to rece | trative staff a report of her finding tor #1 talked with Resident #29 resigned to another area in the facility may be seasons unit at the time the of the allegation made by Resident #29's of the allegation made by Resident mue to provide direct care to reside the incident to be possible abuse into the appropriate state agencie was to be initiated immediately for or visitors who had potential know vestigate and address alleged repeneasures to ensure his or her immess. According to the Social Work sible to remove the alleged perpetion. Administrator #1 was no long d with Administrator #1. Interview ed he was also currently acting as e was not aware of the incident in view with the Vice President of Oty and was working on 04/05/13 verations, the facility's investigation of City and was working on 04/05/13 verations, the facility's investigation of City and was working on 04/05/13 verations, the facility's investigation of City and was working on without the red of the context of the c | gs. The Social garding the reported ty. The Social daughter; and SRNA #14; resident reported the #29, SRNA #14 was ents. In addition, gidi not conduct s. However, review all alleged vledge of the incident; orts, concerns, and ediate safety and er/Abuse Coordinator, as rator from resident ger employed as v conducted on the facility's volving Resident #29, he ordinated the facility's volving Resident #29 reported on of the incident. The moved to another area of . However, the Vice tions related to that did that SRNA #13 had esident's neck too tight mements and an review of the facility's dents of abuse ent. Additional review dation there the concerns, and ediate safety and of the allegation A #13, and SRNA #13 would . A review of the e facility Social ase Coordinator informed the addition, there the concerns, and ediate safety and of the allegation A #13, and SRNA #13 would . A review of the e facility Social ase Coordinator was talking instrator #2 he was not the investigation file there had been an ed the incident investigation file there had been an ed the incident investigation of by the facility dated did not want the Nurse to not of reported no one was o her, and stated it was t. Further review of on 03/24/13. Based on ired cognitive not considered the service a few days ago, he/she tated he/she could g the resident not to not like it. The ide care for him/her; id RN #8 that he/she 7 PM revealed on 03/24/13, esident in the restroom became angry and |

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337
Previous Versions Obsolete

upset and yelled at the RN don't fuss, don't quarrel. RN #8 further stated she went into Resident #8's room again between 2:00 AM and 4:00 AM when the resident's call light was sounding and the resident told the RN he/she did not want the RN to take care of her/him anymore, and stated they could not get along and the resident did not want the Nurse coming in the resident's room anymore. RN #8 further stated around 6:00 AM on 03/24/13 Resident #4 told her she could provide care for her and the resident did not think the RN was mean. Further interview revealed the RN had informed in a casual way RN #9 on B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 around 6:00 PM the DON called and asked the RN to come in early for work. RN #8 stated when she arrived, the DON asked her about the incident on 03/24/13. RN #8 stated she explained the incident and the DON informed her it should have been reported to the DON and Administrator as an allegation of abuse. RN #8 stated after speaking with the DON on 03/27/13 she went out on the floor and worked her twelve (12) hours scheduled shift. Interview with RN #9 on 03/29/13 at 8:02 PM revealed he did remember RN #8 coming to B wing on the morning of 03/24/13 crying. However, he did not remember anything related to Resident #4. Interview with RSNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, RN #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report

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

| CENTERS FOR MEDICARE | & WIEDICAID SERVICES | | | OMB NO. 0938-0391 |
|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCT A. BUILDING B. WING | ION | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF SU LEE COUNTY CARE & REI | | | STREET ADDRESS, CITY, STA 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | L ATE, ZIP |
| For information on the nursing | home's plan to correct this deficien | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIE MATION) | NCY MUST BE PRECEDED BY | Y FULL REGULATORY |
| F 0225 | Notes and did not know what elst to the Weekend Manager becauss #4 went on to state if it had not b revealed RN #4 did not report the stated she didn't feel abuse occur into Resident #4's room. Intervies he was the Manager on Duty on Nurses. According to the Weeker during the early morning. The W incident. The Weekend Manager #8 she did not think the RN was the DON, nor did she report the i was aware of the incident betwee informed her of the situation on ODN did not initiate an investiga Consultant contacted her regarding she called RN #8 and asked her tallowed the RN to continue work initiated on 03/27/13. The DON occurred. Interview with the Coo another corporate staff member to Consultant, the trainee was reviewed between the resident and RN #8. was aware of the incident. The D The Cooperate Nurse Consultant Chief Nurse Executive informed interview had been conducted, she were protected. The Cooperate Nevening of 03/27/13. Interview o3/27/13 concerning the incident statement from the RN and that s President of Operations was awa this is not good, and stated she we thought they needed to suspend to Cooperate Regional Controller on the incident between Resident #4 the Administrator. Further intervieweause, at that point, the investigation; the DON called R1 although he sat in during the inte was permitted to work after being facility's abuse policy revealed the following the incident and during the interval of the incide | RN #4 stated RN #8 informed hee to do about it. RN #4 further state it was charted in the Nurse's Note en charted she wouldn't have beet incident to the DON or Administ red, since the resident was fine, even which the Weekend Manager, who with the Weekend Manager, who Sunday 03/24/13. When she came and Manager, RN #4 informed her cekend Manager stated the DON told her the way the mean. The Weekend Manager state neident to the Administrator. Inter an Resident #4 and RN #8 that had 03/24/13 and she did not give the Vition nor did she notify the Administration or come to the facility for interviewing on 03/27/13 after interviewing the incident after she had read it of come to the facility for interviewing new form of the facility for interviewing new form of the facility for interviewing Resident #4's chart and disconfurther interview revealed she call ON informed her she was, but had stated on 03/27/13 she called the fact the facility for interview RN #8 and obtain the did not conduct a follow-up to elurse Consultant stated she was not with the Chief Nurse Executive on the between RN #8 and Resident #4. The would notify the Cooperate Regy. Further interview revealed she dould notify the Administrator. Acche Nurse, she provided no addition on 03/29/13 at 2:15 PM revealed she and RN #8. She further stated she iew revealed she was not aware R1 gation had just been initiated. Inter 25 AM and 4:11 PM, revealed he the DON acknowledged the incident. W8 into the office to question her riview, he was half paying attention ginterviewed on 03/27/13 while the resident was to receive measures the invisite of the removal dabuse. Further interview with Adate decisions related to the removal dabuse. Further interview with Adate decisions related to the removal dabuse. Further interview with Adate decisions related to the removal dabuse. Further interview with Adate decisions related to the r | ed around 9:00 AM on 03/24/13 ses; in case there was a need to ope no so concerned about reporting it. rator because she didn't see any in erything was fine, and since RN # o was the Dietary Manager, on 03 e in that morning she went to each of the incident that transpired betwith a bound of the incident that transpired betwith EDON around 10:00 AM on 03 he situation was handled was fine ed she did not pursue an investigation with the DON on 04/02/13 a occurred on 03/24/13. She stated Weekend Manager any further inst strator. The DON stated on 03/27 tin the Nurse's Notes. The DON strated on 03/27 tin the Nurse's Notes. The DON strated on 03/27 tin the Nurse's Notes. The DON further stated she and her and prior to the finishing the #2 interviewed RN #8, they deter 1/13 at 7:45 PM revealed on 03/27/1 medical records. According to the wered Nurses' Notes from 03/24/1 led the DON, who was in the buil forgotten to investigate it and rep. Chief Nurse Executive to inform it a ware RN #8 was permitted to wo3/29/13 at 3:25 PM revealed she en in the ware and in the theory of the Chief Nurse Executival in the the coperate Nurse gional Controller, who was in challed in the theory of the Chief Nurse Executival input into the investigation. Interview with Administrator #2 the estigation into the incident. Administrator #2 on 02 occurred ware of the incident Administrator #2 on 02 occurred ware investigation was in progress. Fe to ensure his or her immediate salministrator and/or Director of Nu al of individuals from direct care gliministrator and/or Director of Nu al of individuals from direct care gliministrator and/or Director of Nu al of individuals from direct care gliministrator and progress. Fe to ensure his or her immediate salministrator and/or Director of Nu al of individuals from direct care gliministrator and or Director of Nu al of individuals from direct care gliministrator and was on suspension a progress. Fe was an outer to know the little girl (RN #8 29/13 RN #8 was on suspension a | she reported the incident en an investigation. RN Further interview mmediate harm. RN #4 88 did not go back 1/28/13 at 6/41 PM, revealed 1 Nurse's station to talk with ween RN #8 and Resident #4 8/24/13 to inform her of the since Resident #4 told RN tion after speaking with at 8:45 PM revealed she the Weekend Manager had tructions. However, the 1/13, the Corporate Nurse stated, at that time, 1 Administrator #2 investigation that was mined abuse had not 1/13 she was training e Corporate Nurse 1/3 regarding the incident ding, to question if she sort it to anyone else. her of the findings. The wealed, after the ititated and residents rork the shift on the did receive a call on se Consultant to obtain a rege while the Vice Controller who stated ive, even though she terview with the Chief Nurse Executive of tive that she would notify e evening of 03/27/13 3/28/13 at 2:00 PM; 3/27/13 at approximately DON informed him she had nistrator #2 to conduct an rator #2 stated he was aware the RN lowever, review of the affety and well-being using and/or Social giving or direct contact t think it (the) while I've been |
| | residents; or 2) report and invenistreatment of residents. **NOTE- TERMS IN BRACKE' Based on interview, record reviet the facility failed to have an effect Administrator of the facility, faileviolations were thoroughly inves On 02/17/13 at approximately 7:. the Nurses' station, crying in pair to take Resident #1 to bed and standlering, and/or whining. LPN # staff attempted to report the alleg however, staff was unable to con Worker/Abuse Coordinator's tele Manager on 02/17/13, at approximeted LPN #1 continued to be Staff Development Coordinator/I direction from the Social Worker LPN #1 remained in direct reside to the facility investigation, dated abuse occurred. However, intervithe facility on 02/25/13 related to 03/24/13, at approximately 12:00 that the resident did not want RN resident's room. RN #8 documen Nurse (RN #4) at 7:00 AM. RN # the DON to report the incident. In Administrator of the incident. Administrator of the incident. Administrator of the incident. For eview of Resident #4's medical start of her shift on 03/27/13. Ho residents in the facility during he residents in the facility were prot In addition, the facility were prot In addition, the facility failed to reported to the appropriate State Registered Nurse Aide (SR | estigate any acts or reports of about 18 HAVE BEEN EDITED TO PR w, and review of the facility's invective system to ensure all allegation det to protect residents after an allegitigated for six of twenty-nine samp 35 AM, staff observed Resident #1 n, and requesting to go to bed. Lice the state of the resident would remain sea to place a radio near Resident #1 ted abuse to the Social Worker/Abuse Coophone. Staff reported the allegation mately 11:40 AM, approximately 1 in charge of resident care and rem Nurse Manager initiated the investigation of the state of | OTECT CONFIDENTIALITY** stigation and policy and procedure ns of abuse were reported immedi gation of abuse, and failed to ensu- oled residents (Resident #1, #4, #1 sitting in a wheelchair located in nessed Practical Nurse (LPN) #1 re ted in the wheelchair until the resis s head and turned up the volume. use Coordinator, in accordance wirdinator and left a voice mail mes n of abuse to the Staff Developme four hours after staff observed the tained on the floor with residents of igation, talked with the other staff kursing (DON), and Nurse Consul talety five hours after staff observe was completed the facility unsubst N #1 did not return to the facility effer to F223.) In addition, on the istered Nurse (RN) #8 that RN #8 t anymore; and, asked RN #8 to redical record and reported the inc ekend Manager on 03/24/13, and t an investigation of the incident an Nurse Consultant learned of the i or #2 allowed RN #8 to continue to on 03/27/13 and, as a result, failee while the facility's investigation v gations of abuse were thoroughly iolving Resident #19; Resident #2 yed with cold water and having a | es it was determined lately to the re all alleged 19, #29, #30, and #31). The dining room next to fused to allow staff ident quit crying, According to interviews, ith facility policy; sage on the Social ent Coordinator/Nurse aduring the time the candidate and the same and the s |

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet Page 10 of 59

| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCT | TION | (X3) DATE SURVEY |
|-----------------------------|---|--|--|---|
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | | COMPLETED 04/09/2013 |
| CORRECTION | NUMBER | | | 04/05/2015 |
| NAME OF PROVIDER OF SUPI | 185337 DI IED | | STREET ADDRESS, CITY, STA | TE 7ID |
| LEE COUNTY CARE & REHA | | | 246 EAST MAIN STREET | 110,211 |
| | | | BEATTYVILLE, KY 41311 | |
| | ome's plan to correct this deficience | | , , , | ZELL DECLI ATODY |
| | OR LSC IDENTIFYING INFORM | | ENCY MUST BE PRECEDED BY | FULL REGULATORY |
| F 0225 | OR LSC IDENTIFYING INFORM (continued from page 10) immediately report an allegation of ailure to thoroughly investigate as or death to residents in the facility abuse. The Immediate Jeopardy wt 483.13 Resident Behavior and Fa 03/29/13 and was informed on 04 Allegation of Compliance (AOC) State Survey Agency (SSA) verifiwith remaining noncompliance at develops and implements a Plan octivities. The findings include: 1 the facility to immediately report of resident's property or reasonabincident was to be reported imme. Coordinator, as appropriate, were revealed any report or suspicion oc Coordinator, as appropriate, were revealed any report or suspicion oc direct care giving or direct contact investigation, dated 02/22/13, and AM, with Housekeeper #2 on 03/6(KMA) #1 on 03/01/13 at 12:01 PM, and #1 was observed to abuse Resider protect residents in the facility or #1 attempted to notify the Social' to reach her, and left a message due by the Charge Nurse. Housekeepe Staff Development Coordinator/Nurse undensity at 4:45 PM revealed approximately 11:40 AM, reporti conducted with the Staff Develop on 03/05/13 at 4:45 PM revealed approximately 11:40 AM, reporti Coordinator/Nurse Manager state witness statements, but took no ac Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach was unable to notify the DON of Staff Development Coordinator/Nurse unknown, but was unable to reach the staff Development Coordinator/Nurse unknown, but was unable to reach the staff Development Coordinator/Nurse unknown, but was unab | of abuse, failure to protect resider allegation of abuse caused, or wallegation of abuse callity was roughly 13 the Immediate Jeopardy won 04/17/13 with the facility able in the deference of the facility's abuse power of the comment of the comment of the object of the charge nurse, and the tobe notified immediately by the fain incident of abuse was to be it policy also revealed a thorough in gostaff members, residents, famine would make all reasonable off at them; and that the resident we incident and during the investig of Social Worker would make any trelated to the allegate of the wall with the service of the facility and with the service of the facility and immediately represent of the facility and immediately represent Coordinator/Nurse Manager stated after leaving the voice of the facility and immediately represent Coordinator facility and immediated with the facility and immediated with the facility and immediated facility and immediated facility and immediated facility and sanger stated she did not have to represent facility and immediated facility and immediated facility and immediated facility and assessed by the facility of the facility and assessed facility and assessed facility and facility and facility and facilit | ats during the course of an investig was likely to cause, serious injury, were identified on 03/01/13 and 03 was determined to exist on 02/17/1 otofified of the Immediate Jeopardy as ongoing. The facility provided ging removal of the Immediate Jeopardy on 04/22-04/23/13, as allege or and Facility Practices F225-S/S ectiveness of systemic changes an olicy, dated 01/2012, revealed it was tions of mistreatment, neglect, abunt. The policy stated any report or the Administrator, Director of Nursis charge nurse who receives the remediately reported to the charge worstigation was to be initiated immly, and/or visitors who had potentiforts to investigate and address allefasts to receive measures to ensure heation process. The policy further simmediate decisions related to the dabuse. Based on a review of the on 02/28/13 at 12:17 PM and agaif on 03/01/13 at 12:29 PM, with I worlded by SRNA #2 (unable to be remediately taken by the staff who we mediately taken by the staff who we had to the dabuse of the facility's policy, via p. Housekeeper #1 and Housekeepe not know what to do, since the aborder what she had witnessed to he or 002/28/13 at 5:35 PM, on 03/03 and was approached by Houseke neering Resident #1 and LPN #1. staff related to the incident and health of the context of the con | ation of abuse, and harm, impairment, 1/24/13 related to 3 and is ongoing at 42 CFR on 0.3/01/13 and an acceptable credible pardy on 04/17/13. The di in the acceptable AOC, 1/2, while the facility di quality assurance as the intent of see, misappropriation suspicion of an ng and Abuse oort. Further review nurse and/or Abuse neediately for all al knowledge of the ged reports, is or her immediate tated the removal of individuals from facility's in on 0.3/04/13 at 11:37 Kentucky Medication Aide eached for interview), LPN itnessed the abuse to when the suspicion of an on 0.3/04/13 at 11:37 Kentucky Medication Aide eached for interview), LPN itnessed the abuse to when the suspicion of the suspicion |

Facility ID: 185337

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF SU LEE COUNTY CARE & RE | | 246 EAS | ADDRESS, CITY, STATE, ZIP T MAIN STREET YVILLE, KY 41311 |
| For information on the nursing (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D | | state survey agency. UST BE PRECEDED BY FULL REGULATORY |
| F 0225 | OR LSC IDENTIFYING INFORM (continued from page 11) incident and informed Resident # Worker/Abuse Coordinator stated and a written statement from a sta- incident. The Social Worker/Abuse Coordinator ther investigation of the allegar of the facility's policy on abuse re incidents of abuse involving staff the Administrator/designee would grievances presented to them; and wellbeing following the incident- part of her responsibilities of abuse care and to provide administrative Administrator of the facility and a 04/05/13, at 6:05 PM, with the Vi Administrator. The Vice Presiden would attempt to locate the facilit at 7:30 PM revealed SRNA #14 h the incident to the surveyor. Acco- consisted of the interviews that he stated effective 04/05/13 SRNA # Vice President of Operations stated the facility to work due to a reside President of Operations stated he resident's concern. 3. A review of repeatedly sprayed cold water on following the shower on 03/22/12 investigation was started on 03/22 policy on abuse revealed at thorou involving staff members, resident on 04/09/13, revealed that SRP, appropriate State Agencies until (was no evidence the allegad perp Administrator/designee would ma grievances presented to them; and wellbeing following the incident; dated 04/09/13, revealed that SRP, be suspended and not allowed to facility's investigation log reveale Worker/Abuse Coordinator, it wa Administrator and the Director of investigation of the allegation tha Administrator and the Director of investigation of abuse that he planne occurred on 03/24/13, was reports as moderately impaired when a si with Resident #3 on 03/24/13, h aware of the allegation of abuse tha the incident had not been initiated. Ry #8; however, documentation the investigation revealed RN #8 the facility's investigation of abuse tha investigation of abuse that he planne occurred on 03/24/13, was reports as moderately impaired when a si with Resident #4 on 03/24/13, h aware of the allegation of abuse tha investigation of abuse that he planne occurred | 29 that SRNA #14 would be reassigned to at a she obtained verbal statements from Resid off Nurse that had been assigned to the Seas se Coordinator stated as a result of the alleg acility and was permitted to continue to promator stated she had not considered the incidion; and did not report the incident to the a swaled a thorough investigation was to be in members, residents, family, and/or visitors I make all reasonable efforts to investigate at that the resident was to receive measures that during the investigation process. Accomes investigations, she was responsible to rerestaff the results of her investigation. Admin interview could not be obtained with Adice President of Operations revealed he was at of Operations stated although he was not a sty's investigation. Continued interview with add continued to work at the facility and was ording to the Vice President of Operations, to ad been obtained by the Social Worker/Abu (14) had been suspended from employment ped he did recall Administrator #1 telling hin ent telling staff he/she did not want SRNA # could not recall the resident's name and did a facility's investigation revealed on 03/24/the resident during a shower and had wrapp from 8:00 PM to 9:00 PM. According to in 4/13 by the facility's Social Worker/Abuse C gish investigation was to be initiated immedia, family, and/or visitors who had potential had not completed the investigation and had 4/09/13, sixteen (16) days after the alleged etrator had been suspended. However, the face all reasonable efforts to investigate and that the resident was to receive measures to a she and during the investigation process. Accom VA #13 was not on duty, the facility had attwork until the investigation for a declared the do no entry regarding Resident #30. An intervious the facility and the facility was in the president said and been suspended. However, the face of the allegent of the proper seasonable efforts to investigate and that the resident was to receive measures to a suspension of the propersident face of the | another area in the facility. The Social lent #29; Resident #29's daughter; and SRNA #14; ons unit at the time the resident reported the gation made by Resident #29, SRNA #14 was ovide direct care to residents. In addition, lent to be possible abuse; did not conduct pproportiate state agencies. However, review nitiated immediately for all alleged who had potential knowledge of the incident; and address alleged reports, concerns, and to ensure his or her immediate safety and ding to the Social Worker/Abuse Coordinator, as move the alleged perpetrator from resident innistrator #1 was no longer employed as ministrator #1. Interview conducted on also currently acting as the facility's aware of the incident involving Resident #29, he the Vice President of Operations on 04/05/13 s working on 04/05/13 when Resident #29 reported the facility's investigation of the incident. The in SRNA #14 had been moved to another area of #14 providing their care. However, the Vice In tot ask additional questions related to that /13, Resident #30 alleged that SRNA #13 had oed a sheet around the resident's neck too tight nivestigation witness statements and an Coordinator. However, review of the facility's iately for all alleged incidents of abuse knowledge of the incident. Additional review I failed to report the allegation to the incident was reported. In addition, there acility's policy revealed the address alleged reports, concerns, and to ensure his or her immediate safety and ding to the initial report of the allegation to the uncident was reported. In addition, there acility's policy revealed the address alleged reports, concerns, and to ensure his or her immediate safety and ding to the initial report of the allegation to the patential of the proper state, the facility's holes of the proper state, the facility's policy revealed the safety and ding to the initial report of the allegation to the buse Coordinator stated, the facility's not been completed. Interview of the review conducted with the facility's not been completed. In |

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 Previous Versions Obsolete Page 12 of 59

related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, R #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report the information to the DON or Administrator as she had been instructed to. Interview with RN #4 on 03/29/13 at 7:35 PM revealed she worked on the morning of 03/24/13. According to RN #4, RN #8 informed her during change of shift of the incident between the RN and Resident #8. RN #4 stated RN #8 informed her she had documented the incident in the resident's Nurse's Notes and did not know what else to do about it. RN #4 further stated around 9:00 AM on 03/24/13 she reported the incident to the Weekend Manager because it was charted in the Nurse's Notes; in case there was a need to open an investigation. RN

| DEPARTMENT OF HEALTH AND HUMAN SER | VICES |
|--------------------------------------|-------|
| CENTERS FOR MEDICARE & MEDICAID SERV | ICES |

| | | | | OMB NO. 0938-0391 |
|---------------------------|---|---|--|---|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCTIO | | (X3) DATE SURVEY |
| DEFICIENCIES | / CLIA | A. BUILDING | | COMPLETED |
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | B. WING | | 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SUI | | ST | TREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & REH | IABILITATION CENTER | 24 | 46 EAST MAIN STREET | |
| | | - | EATTYVILLE, KY 41311 | |
| | | cy, please contact the nursing home | | |
| (X4) ID PREFIX TAG | OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIEN MATION) | CY MUST BE PRECEDED BY | 7 FULL REGULATORY |
| F0225 | (continued from page 12) #4 went on to state if it had not be revealed RN #4 did not report the stated she didn't feel abuse occur into Resident #4's room. Intervies he was the Manager on Duty on Nurses. According to the Weeker during the early morning. The Wincident. The Weekend Manager #8 she did not think the RN was the DON, nor did she report the is was aware of the incident betwee informed her of the situation on OON did not initiate an investiga Consultant contacted her regarding she called RN #8 and asked her tallowed the RN to continue work initiated on 03/27/13. The DON occurred. Interview with the Cool another corporate staff member were Consultant, the trainee was revieween the resident and RN #8. was aware of the incident. The D The Cooperate Nurse Consultant Chief Nurse Executive informed interview had been conducted, she were protected. The Cooperate Nevening of 03/27/13. Interview wo 3/27/13 concerning the incident statement from the RN and that she president of Operations was awathis is not good, and stated she wthought they needed to suspend tooperate Regional Controller of the incident between Resident #4 the Administrator. Further intervieweause, at that point, the investigation; the DON called Rialthough he sat in during the intewas permitted to work after bein investigation; the DON called Rialthough he sat in during the interval and the support of the investigation; the DON called Rialthough he sat in during the interval and the support of the interval | een charted she wouldn't have been se incident to the DON or Administrated, since the resident was fine, ever with the Weckend Manager, who volumed you with the Weckend Manager, who would you will have been seekend Manager stated she called the stated the DON told her the way the mean. The Weckend Manager stated neident to the Administrator. Interview in Resident #4 and RN #8 that had on 30/24/13 and she did not give the Westion nor did she notify the Administrator in the incident after she had read it in the common of the facility for interview. In go no 30/27/13 after interviewing his tated after she and Administrator #2 perate Nurse Consultant on 03/28/13 while performing audits of resident in wing Resident #4's chart and discove Further interview revealed she called ON informed her she was, but had for stated on 03/27/13 she called the Cher to interview RN #8 and obtain a le did not conduct a follow-up to ensures Consultant stated she was not a with the Chief Nurse Executive on 03 between RN #8 and Resident #4. She he would notify the Cooperate Regic y. Further interview revealed she did ould notify the Administrator. According the revealed she was not a ware RN #8. She further stated she in the Verse of the PoN regarding the incident. According to the work of the provided no additional no 3/29/13 at 2:15 PM revealed she was not a ware RN #8. She further stated she in the verse of the PoN regarding the incident. According to the provident in the work of the provident of the work of the provident of the work of the PoN regarding the incident. According to the provident in the work of the provident of the work | tor because she didn't see any in ything was fine, and since RN # was the Dietary Manager, on 03 n that morning she went to each the incident that transpired betwee DON around 10:00 AM on 03 e situation was handled was fine I she did not pursue an investigate we with the DON on 04/02/13 a ccurred on 03/24/13. She stated sekend Manager any further inst rator. The DON stated on 03/27, n the Nurse's Notes. The DON 5 The DON further stated she and her and prior to the finishing the 2 interviewed RN #8, they deterr 3 at 7:45 PM revealed on 03/27/1 dthe DON, who was in the built orgotten to investigate it and repaired Nurse Executive to inform h statement. Interview further revisite an investigate it and repaired Nurse Executive to inform h statement. Interview further revisite an investigation had been insurare RN #8 was permitted to w/29/13 at 3:25 PM revealed she had inotify the Corporate Regional Controller, who was in chall notify the Corporate Regional Griding to the Chief Nurse Executive to inform h was not field on 03/27/13 by the Informed the Chief Nurse Executive Was notified on 03/27/13 by the Informed the Chief Nurse Executive Was not find the Chief Nurse Executive Was not find to the Chief Nurse Executive Was not find the Mass permitted to we with Administrator #2 t | nmediate harm. RN #4 8 did not go back /28/13 at 6:41 PM, revealed Nurse's station to talk with /een RN #8 and Resident #4 /24/13 to inform her of the since Resident #4 told RN tion after speaking with to amyone else. The after the did receive a call on the consultant to obtain a to after the did receive a call on the consultant to obtain a to after speaking with the Chief Nurse Executive of the five that she would notify to evening of 03/27/13 to after speaking with the Chief Nurse Executive of the that she would notify to evening of 03/27/13 to after speaking with the Chief Nurse Executive of the that she would notify to evening of 03/27/13 to after speaking with the Chief Nurse Executive of the think it the think it (the to while I've been |
| F 0225 | residents; or 2) report and invenistreatment of residents. **NOTE- TERMS IN BRACKE' Based on interview, record reviet the facility failed to have an effect Administrator of the facility, failviolations were thoroughly inves On 02/17/13 at approximately 7:. the Nurses' station, crying in pair to take Resident #1 to bed and stabellering, and/or whining. LPN # staff attempted to report the alleg however, staff was unable to con Worker/Abuse Coordinator's tele Manager on 02/17/13, at approximeted LPN #1 continued to be Staff Development Coordinator'd direction from the Social Worker LPN #1 remained in direct reside to the facility investigation, dated abuse occurred. However, intervithe facility on 02/25/13 related to 03/24/13, at approximately 12:00 that the resident did not want RN resident's room. RN #8 documen Nurse (RN #4) at 7:00 AM. RN # the DON to report the incident. Or review of Resident #4's medical start of her shift on 03/27/13. Ho residents in the facility during he residents in the facility were profun addition, the facility were profun addition, the facility were profun addition, the facility shilled to eported to the appropriate State Registered Nurse Aide (SR his/her neck; and, Resident #31 himmediately report an allegation failure to thoroughly investigate. | I history of abusing, neglecting or stigate any acts or reports of abusings. Have BEEN EDITED TO PROW, and review of the facility's investive system to ensure all allegations deto protect residents after an allegations to the facility's investive system to ensure all allegations of the protect residents after an allegatigated for six of twenty-nine sample \$5.4 M, staff observed Resident #1's to, and requesting to go to bed. Licens ted the resident would remain seated placed a radio near Resident #1's to abuse to the Social Worker/Abuse Coordinater H1's for abusing the state the Social Worker/Abuse Coordinater H1's Have Beautiful H1:40 AM, approximately for in charge of resident care and remainsurse Manager initiated the investige Abuse Coordinator, Director of Nur and rear until 12:30 PM, approximate 102/22/13, after the investigation was ewand record review revealed LPN falsification of documentation. (Ref. AM, Resident #4 reported to Regist #8 to provide care for the resident act the incident in Resident #4's med #4 reported the incident to the Weeke However, the DON and Administrator #6 residents (103/27/13), the facility's Cooperate Necord. The DON and Administrator #6 resident ded the incident in Resident #4's med #4 reported the welve (12) hour shift or exceed from further potential allegat Agencies; alleged verbal abuse invol NA) #14: Resident #30 being spraye eing handled roughly by staff while of abuse, failure to protect residents an allegation of abuse caused, or was y. Immediate Jeopardy situations we | re, neglect or TECT CONFIDENTIALITY** igation and policy and procedure of abuse were reported immedi- tion of abuse, and failed to ensu- ed residents (Resident #1, #4, #1 itting in a wheelchair located in sed Practical Nurse (LPN) #1 ret d in the wheelchair until the resi- head and turned up the volume the Coordinator, in accordance wi linator and left a voice mail mess of abuse to the Staff Developme ur hours after staff observed the ined on the floor with residents cation, talked with the other staff rsing (DON), and Nurse Consult- ly five hours after staff observed as completed the facility unsubst #1 did not return to the facility fer to F223.) In addition, on the tered Nurse (RN) #8 that RN #8 unymore; and, asked RN #8 to not lical record and reported the inci- end Manager on 03/24/13, and the investigation of the incident an furse Consultant learned of the in #2 allowed RN #8 to continue to n 03/27/13 and, as a result, failed thile the facility's investigation w tions of abuse were thoroughly i lying Resident #19; Resident #2 with cold water and having a being placed in a chair. The fac during the course of an investig s likely to cause, serious injury, | es it was determined ately to the ire all alleged 9, #29, #30, and #31). the dining room next to fused to allow staff dent quit crying, According to interviews, the facility policy; sage on the Social ent Coordinator/Nurse abuse. Interviews during the time the and attempted to get tant on what action to take. It does not always to the social ent coordinated that and was terminated from morning of was mean to the resident; of come back into the dident to the oncoming the Weekend Manager contacted did not notify the neident through the incident through the incident prior to the provide direct care to does not social entire to the oncoming the was in progress. Investigated and 9 expressing fear of towel wrapped around lility's failure to aition of abuse, and harm, impairment, |

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 13 of 59

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

LEE COUNTY CARE & REHABILITATION CENTER

PRINTED:3/30/2014 FORM APPROVED

| | | | OMB NO. 0938-0391 |
|-------------------------|---|---------------------------|---|
| DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | A. BUILDING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 185337 | | |
| NAME OF PROVIDER OF SUP | PLIER | STREET ADDRESS, CITY, STA | ATE, ZIP |

246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG

F 0225

(continued... from page 13)
abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR
483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and
03/29/13 and was informed on 04/09/13 he Immediate Jeopardy was ongoing. The facility provided an acceptable credible
Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The
State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22/04/23/13, as alleged in the acceptable AOC,
with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F225- S/S E, while the facility
develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance
activities. The findings include: 1. Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of
the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation
of resident's property or reasonable suspicion of criminal act or intent. The policy stated any report or suspicion of an
incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse
Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review
revealed any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse
Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all
alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the
incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports,
concerns, and grievances presented to them; and that the resident was to receive measures to ensure

(KMA) #1 on 03/01/13 at 12:01 PM, and review of a witness statement provided by SRNA #2 (unable to be reached for interview), LPN #1 was observed to abuse Resident #1. However, no action was immediately taken by the staff who witnessed the abuse to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, when Housekeeper #1 attempted to notify the Social Worker/Abuse Coordinator, as directed in the facility's policy, via phone, but was unable to reach her, and left a message describing what she had witnessed. Housekeeper #1 and Housekeeper #2 stated they did not immediately report the abuse due to being nervous, scared, and did not know what to do, since the abuse had been committed by the Charge Nurse. Housekeeper #1 stated after leaving the voice message for the Abuse Coordinator, she observed the Staff Development Coordinator in the facility and immediately reported what she had witnessed to her. An interview conducted with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, on 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and was approached by Housekeepers #1 and #2 at approximately 11:40 AM, reporting the incident they witnessed concerning Resident #1 and LPN #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness extrements whit took necessarily the staff related to the incident and had staff fill out witness extrements whit took necessarily the staff related to the whole Nurse Manager. witness statements, but took no action to protect residents in the facility from further abuse by the LPN. The Staff Development Coordinator/Nurse Manager stated she did not have the authority to remove LPN #1 (Charge Nurse) from patient Development Coordinator/Nurse Manager stated she also not have the authority to renove Err with Charge Nurse) from patient care, stating only the Administrator, Social Worker/Abuse Coordinator, or Director of Nursing had that authority. The Staff Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time unknown, but was unable to reach her and left a voice message. The Staff Development Coordinator/Nurse Manager stated she was unable to notify the DON of the alleged abuse due to not having access to her current phone number. According to the Staff Development Coordinator/Nurse Manager, LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse was observed) when the Staff Development Coordinator/Nurse Manager contacted the facility's Nurse Consultant via telephone and was instructed to suspend LPN #1, the Charge Nurse. However, review of the facility's policy revealed residents would receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed once she discovered and listened to the voice messages from Housekeeper #1 and the Staff Development Coordinator/Nurse Manager on 02/17/13 (time unknown) she went to the facility to assist with the investigation. According to the Social Worker/Abuse Coordinator staff was required to report any allegations of abuse to the Abuse Coordinator (herself), the Administrator, the DON, or the Charge Nurse. However, the facility had no specific detailed reporting procedure such as an on call system, to ensure staff was able to report abuse as the facility policy directs. The Social Worker/Abuse Coordinator stated there was no written order of whom to report abuse to, and staff would have to go through the individuals listed in the policy until one was reached. The Social Worker/Abuse Coordinator further stated she was allowed to remove alleged perpetrators from resident care and she was unaware if another Nurse had the authority to remove alleged perpetrators from direct care after an allegation of abuse had been alleged. Interview further revealed when an allegation of abuse was made she, the DON, and the Administrator, performed the investigation. According to the Social Worker/Abuse Coordinator depending on who got to the facility first, the others would just see who did what and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible for the decision to determine if a staff member had committed an abusive act toward a resident, and made decisions regarding all disciplinary action. Review of the facility's policy revealed only the Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Administrator #1 stated in an interview conducted on 02/28/13 at 5:20 PM that his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. According to Administrator #1 when he interviewed LPN #1, she did confirm Resident #1 was crying and yelling at the Nurses' station and she (the Charge Nurse) instructed staff to leave the resident up in the chair, but explained that it was to observe the resident. Administrator #1 also acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson. Additionally, the Abuse Coordinator had reported that although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition, an alert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously. However, after considering all the information that had been obtained during the investigation, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1, and therefore unsubstantiated the allegation, and took no further disciplinary action against LPN #1 in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. At the time of the investigation, LPN #1, the Charge Nurse, was no longer employed by the facility, and attempts to interview her were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #29 on 03/18/10 with [DIAGNOSES REDACTED]. A list of residents assessed by the facility to be alert, oriented and interviewable was provided on 04/02/13. According to the list, the facility had assessed Resident #29 to be alert, oriented, and interviewable. Resident #29 was observed sitting in a wheelchair in the facility dining room on 04/05/13 at 5:50 PM. Interview conducted on 04/05/13, at 5:50 PM with Resident #29 revealed he/she was afraid of a staff person (SRNA #14). The resident stated SRNA #14 had touched his/her breast when the SRNA hugged the resident approximately 2-3 months ago, and would come into the resident's room without knocking when the resident was disrobed. Resident #29 stated he/she reported the incident that occurred 2-3 months ago to the facility's Social Worker/Abuse Coordinator at the time the incident to cocurred. The resident stated SRNA #14 had been moved to another area in the facility after he/she reported the incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had bouched the resident's breast and, although Resident revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had touched the resident's breast and, although Resident #29 reportedly did not feel SRNA #14's action was abuse, the resident felt the his actions were inappropriate. According to the Social Worker/Abuse Coordinator, she had the responsibility to investigate allegations of abuse, to report the the Social Worker/Abuse Coordinator, she had the responsibility to investigate anegations of another to the appropriate state agencies, and to provide administrative staff a report of her findings. The Social Worker/Abuse Coordinator stated on 03/01/13, she and Administrator #1 talked with Resident #29 regarding the reported incident and informed Resident #29 that SRNA #14 would be reassigned to another area in the facility. The Social Worker/Abuse Coordinator stated she obtained verbal statements from Resident #29; Resident #29's daughter; and SRNA #14; and a written statement from a staff Nurse that had been assigned to the Seasons unit at the time the resident reported the

Facility ID: 185337

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

PRINTED:3/30/2014 FORM APPROVED

| | | | OMB NO. 0938-0391 |
|-----------------------------|-----------------------------|--|---|
| DEFICIENCIES AND PLAN OF | CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 185337 | | |
| NAME OF PROVIDED OF SLIPE | DI IEB | STREET ADDRESS CITY ST | ATE 7IP |

LEE COUNTY CARE & REHABILITATION CENTER

246 EAST MAIN STREET BEATTYVILLE, KY 41311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG

F 0225

(continued... from page 14) incident. The Social Worker/Abuse Coordinator stated as a result of the allegation made by Resident #29, SRNA #14 was reassigned to another unit of the facility and was permitted to continue to provide direct care to residents. In addition, the Social Worker/Abuse Coordinator stated she had not considered the incident to be possible abuse; did not conduct further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review

further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the Social Worker/Abuse Coordinator, as part of her responsibilities of abuse investigations, she was responsible to remove the alleged perpetrator from resident care and to provide administrative staff the results of her investigation. Administrator #1 was no longer employed as Administrator of the facility and an interview could not be obtained with Administrator #1. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not agree of the incident involving Resident #29, he 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not aware of the incident involving Resident #29, he would attempt to locate the facility's investigation. Continued interview with the Vice President of Operations on 04/05/13 at 7:30 PM revealed SRNA #14 had continued to work at the facility and was working on 04/05/13 when Resident #29 reported the incident to the surveyor. According to the Vice President of Operations, the facility's investigation of the incident consisted of the interviews that had been obtained by the Social Worker/Abuse Coordinator. The Vice President of Operations stated effective 04/05/13 SRNA #14 had been suspended from employment pending further investigation of the incident. The Vice President of Operations stated he did recall Administrator #1 telling him SRNA #14 had been moved to another area of the facility to work due to a resident telling staff he/she did not want SRNA #14 providing their care. However, the Vice President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. According to investigation witness statements and an investigation was started on 03/24/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's investigation was started on 03/24/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident. Additional review on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the appropriate State Agencies until 04/09/13, sixteen (16) days after the alleged incident was reported. In addition, there was no evidence the alleged perpetrator had been suspended. However, the facility's policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the initial report of the allegation dated 04/09/13, revealed that SRNA #13 was not on duty, the facility had attempted to contact SRNA #13, and SRNA #13 would be suspended and not allowed to work until the investigation had cleared the SRNA of the allegation. A review of the facility's investigation log revealed no entry regarding Resident #30. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed, on 04/08/13, the Social Worker/Abuse Coordinator informed the Administrator of the allegation of abuse that had occurred on 03/22/13 and involved Resident #30. According to the Social Worker/Abuse Coordinator, it was the Social Worker/Abuse Coordinator's responsibility to report the allegation to the Administrator and the Director of Nursing. In addition, the Social Worker/Abuse Coordinator stated, the facility's investigation of the allegation that had reportedly occurred on 03/22/13 had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talking with Resident #30 on 03/24/13, however; was not aware of an abuse allegation. According to Administrator #2 he was not Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talk with Resident #30 on 03/24/13, however; was not aware of an abuse allegation. According to Administrator #2 he was not aware of the allegation of abuse had not been thoroughly investigated and reported as required until the investigation file was found on 04/08/13. 4. Interview with facility Administrator #2 on 03/28/13 at 1:50 PM revealed there had been an allegation of abuse that he planned to report to the appropriate State Agencies. Administrator #2 stated the incident occurred on 03/24/13, was reported on 03/27/13, and the facility was in the process of conducting an investigation. According to Administrator #2, a resident said a Nurse was mean to her/him, but no abuse occurred. Administrator #2 further stated the DON was aware of the allegation on 03/24/13, the date of the alleged abuse, and confirmed an investigation of the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was mean to the resident and the resident did not want the Nurse to provide care for her/him. According to the investigation Resident #8 was interviewed on 03/28/13, and reported no one was mean to her/him. The investigation also revealed the resident reported one of the women was mean to her and stated it was the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was ment to the resident and the resident did not want the Nurse to provide care for her/him. The investigation also revealed the resident reported one of the women was men to the resident was the resident and the resident was the resident was RN #8; however, documentation in the report revealed the resident stated he/she didn't really mean it. Further review of the investigation also revealed RN #8 verified Resident #4 had told her that she was mean to the resident's cognitive ability. Review of Resident #4 she dated record revealed on 02/01/13 the facility assessed the resident's cognition level as moderately impaired when a significant change in status Minimum Data Set (MDS) assessment had been completed. Interview with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she needed to go to the restroom during the night and turned the call light on to alert staff. Resident #4 stated he/she could not wait and went to the restroom alone. According to Resident #4, RN #8 came in and started telling the resident not to get up unassisted and to wait for help. Resident #4 stated RN #8 was being foud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not want the RN to provide care for him/her; and, not to come back into the resident's froom. Resident #4 stated RN #8 was being foud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not want the RN to provide care for him/her; and, not to come back into the resident's froom. Resident #4 stated that later in the morning, he/she told RN #8 that he/she was sorry and the resident to the tresident froom. Resident #4 tage the call light and the RN tent into the room and instructed the resident to wait for assi

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:3/30/2014

| LEE COUNTY CARE & REHABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
|---|---------------------------------|---|------------------------------------|
| NAME OF PROVIDER OF SUPPLIER | | STREET ADDRESS, CITY, ST | ATE, ZIP |
| | 185337 | | |
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | A. BUILDING B. WING | 04/09/2013 |
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| CENTERS FOR MEDICARI | E & MEDICAID SERVICES | | FORM APPROVED OMB NO. 0938-0391 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

F 0225

(continued... from page 15) into Resident #4's room. Interview with the Weekend Manager, who was the Dietary Manager, on 03/28/13 at 6:41 PM, revealed she was the Manager on Duty on Sunday 03/24/13. When she came in that morning she went to each Nurse's station to talk with Nurses. According to the Weekend Manager, RN #4 informed her of the incident that transpired between RN #8 and Resident #4 during the early morning. The Weekend Manager stated she called the DON around 10:00 AM on 03/24/13 to inform her of the incident. The Weekend Manager stated the DON told her the way the situation was handled was fine since Resident #4 told RN #8 she did not think the RN was mean. The Weekend Manager stated she did not pursue an investigation after speaking with the DON, nor did she report the incident to the Administrator. Interview with the DON on 04/02/13 at 8:45 PM revealed she was aware of the incident between Resident #4 and RN #8 that had occurred on 03/24/13. She stated the Weekend Manager had informed her of the situation on 03/24/13 and she did not give the Weekend Manager any further instructions. However, the informed her of the situation on 03/24/13 and she did not give the Weekend Manager any further instructions. However, the DON did not initiate an investigation nor did she notify the Administrator. The DON stated on 03/27/13, the Corporate Nurse Consultant contacted her regarding the incident after she had read it in the Nurse's Notes. The DON stated, at that time, she called RN #8 and asked her to come to the facility for interview. The DON further stated she and Administrator #2 allowed the RN to continue working on 03/27/13 after interviewing her and prior to the finishing the investigation that was initiated on 03/27/13. The DON stated after she and Administrator #2 interviewed RN #8, they determined abuse had not occurred. Interview with the Cooperate Nurse Consultant on 03/28/13 at 7:45 PM revealed on 03/27/13 she was training another corporate staff member while performing audits of resident medical records. According to the Corporate Nurse Consultant, the trainee was reviewing Resident #4's chart and discovered Nurses' Notes from 03/24/13 regarding the incident between the resident and RN #8. Further interview revealed she called the DON, who was in the building, to question if she was aware of the incident. The DON informed her she was, but had forgotten to investigate it and report it to anyone else. The Cooperate Nurse Consultant stated on 03/27/13 she called the Chief Nurse Executive to inform her of the findings. The Chief Nurse Executive informed her to interview RN #8 and obtain a statement. Interview further revealed, after the interview had been conducted, she did not conduct a follow-up to ensure an investigation had been initiated and residents Chief Nurse Executive informed her to interview RN #8 and obtain a statement. Interview further revealed, after the interview had been conducted, she did not conduct a follow-up to ensure an investigation had been initiated and residents were protected. The Cooperate Nurse Consultant stated she was not aware RN #8 was permitted to work the shift on the evening of 03/27/13. Interview with the Chief Nurse Executive on 03/29/13 at 3:25 PM revealed she did receive a call on 03/27/13 concerning the incident between RN #8 and Resident #4. She instructed the Cooperate Nurse Consultant to obtain a statement from the RN and that she would notify the Cooperate Regional Controller, who was in charge while the Vice President of Operations was away. Further interview revealed she did notify the Corporate Regional Controller who stated this is not good, and stated she would notify the Administrator. According to the Chief Nurse Executive, even though she thought they needed to suspend the Nurse, she provided no additional input into the investigation. Interview with the Cooperate Regional Controller on 03/29/13 at 2:15 PM revealed she was notified on 03/27/13 by the Chief Nurse Executive of the incident between Resident #4 and RN #8. She further stated she informed the Chief Nurse Executive that she would notify the Administrator. Eurther interview revealed she was not aware RN #8 was permitted to work on the evening of 03/27/13 the Administrator. Further interview revealed she was not aware RN #8 was permitted to work on the evening of 03/27/13 because, at that point, the investigation had just been initiated. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM, revealed he became aware of the incident on 03/27/13 at approximately 5:40 PM and went to speak with the DON regarding the incident. According to Administrator #2 the DON informed him she had forgotten to notify him of the allegation and failed to initiate an investigation into the incident. Administrator #2 further stated on 03/27/13 when the DON acknowledged the incident and reported she had forgotten to conduct an investigation; the DON called RN #8 into the office to question her regarding the incident. Administrator #2 stated although he sat in during the interview, he was half paying attention. Administrator #2 further stated he was aware the RN was permitted to work after being interviewed on 03/27/13 while the investigation was in progress. However, review of the facility's abuse policy revealed the resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Further interview with Administrator #2 revealed he did not think it (the allegation) was reportable, he stated in my heart of hearts I have gotten to know the little girl (RN #8) while I've been here, I just didn't feel it was true and reportable. He stated as of 03/29/13 RN #8 was on suspension and the decision to

F 0225

1) Hire only people with no legal history of abusing, neglecting or mistreating residents, or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately to the Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged

Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged violations were thoroughly investigated for six of twenty-nine sampled residents (Resident #1, #4, #19, #29, #30, and #31). On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the Nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing (DON), and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. According to the facility investigation, dated 02/22/13, after the investigation was completed the facility unsubstantiated that abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on t abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on the morning of 03/24/13, at approximately 12:00 AM, Resident #4 reported to Registered Nurse (RN) #8 that RN #8 was mean to the resident; that the resident did not want RN #8 to provide care for the resident anymore; and, asked RN #8 to not come back into the resident's room. RN #8 documented the incident in Resident #4's medical record and reported the incident to the oncoming Nurse (RN #4) at 7:00 AM. RN #4 reported the incident to the Weekend Manager on 03/24/13, and the Weekend Manager contacted the DON to report the incident. However, the DON did not initiate an investigation of the incident and did not notify the Administrator of the incident. On 03/27/13, the facility's Cooperate Nurse Consultant learned of the incident through review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the start of her shift on 03/27/13. However, the DON and Administrator #2 allowed RN #8 to continue to provide direct care to residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility were protected from further potential abuse while the facility's investigation was in progress. In addition, the facility failed to ensure four (4) other potential allegations of abuse were thoroughly investigated and reported to the appropriate State Agencies; alleged verbal abuse involving Resident #19; Resident #29 expressing fear of State Registered Nurse Aide (SRNA) #14; Resident #30 being sprayed with cold water and having a towel wrapped around his/her neck; and, Resident #31 being handled roughly by staff while being placed in a chair. The facility's failure to immediately report an allegation of abuse, failure to protect residents during the course of an investigation of abuse, and failure to thoroughly investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible

Facility ID: 185337

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

If continuation sheet Page 16 of 59

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

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION) CLIA IDENNTIFICATION À. BUILDING B. WING ____ 04/09/2013 NUMBER 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 16)
Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F225- S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: 1. Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate F 0225 incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Based on a review of the facility's investigation, dated 02/22/13, and interviews with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM, with Housekeeper #2 on 03/01/13 at 11:47 AM, with SRNA #3 on 03/01/13 at 12:29 PM, with Kentucky Medication Aide (KMA) #I on 03/01/13 at 12:01 PM, and review of a witness statement provided by SRNA #2 (unable to be reached for interview), LPN #1 was observed to abuse Resident #1. However, no action was immediately taken by the staff who witnessed the abuse to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, when Housekeeper #1 attempted to notify the Social Worker/Abuse Coordinator, as directed in the facility's policy, via phone, but was unable to reach her, and left a message describing what she had witnessed. Housekeeper #1 and Housekeeper #2 stated they did not immediately report the abuse due to being nervous, scared, and did not know what to do, since the abuse had been committed by the Charge Nurse. Housekeeper #1 stated after leaving the voice message for the Abuse Coordinator, she observed the Staff Development Coordinator in the facility and immediately reported what she had witnessed to her. An interview conducted with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, on 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and was approached by Housekeepers #1 and #2 at approximately 11:40 AM, reporting the incident they witnessed concerning Resident #1 and LPN #1. The Staff Development Coordinator/Nurse Manager stated she did not have the authority to remove LPN #1 (Charge Nurse) from patient care, stating only the Administrator, Social Worker/Abuse Coordinator, or Director of Nursing had that authority. The Staff Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time unknown, but was unable to reach her and left a voice message. The Staff Development Coordinator/Nurse Manager stated she was unable to notify the DON of the alleged abuse due to not having access to her current phone number. According to the Staff Development Coordinator/Nurse Manager, LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse was observed) when the Staff Development Coordinator/Nurse Manager contacted the facility's Nurse Consultant via telephone and was instructed to suspend LPN #1, the Charge Nurse. However, review of the facility's policy revealed residents would receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed once she discovered and listened to the voice messages from Housekeeper #1 and the Staff Development Coordinator/Nurse Manager on 02/17/13 (time unknown) she went to the facility to assist with the investigation. According to the Social Worker/Abuse Coordinator staff was required to report any allegations of abuse to the Abuse Coordinator (herself), the Administrator, the DON, or the Charge Nurse. However, the facility had no specific detailed reporting procedure such as an on call system, to ensure staff was able to report abuse as the facility policy directs. The Social Worker/Abuse Coordinator stated there was no written order of whom to report abuse to, and staff would have to go through the individuals listed in the policy until one was reached. The Social Worker/Abuse Coordinator further stated she was allowed to remove alleged perpetrators from resident care and she was unaware if another Nurse had the authority to remove alleged perpetrators from direct care after an allegation of abuse had been alleged. Interview further revealed when an allegation of abuse was made she, the DON, and the Administrator, performed the investigation. According to the Social Worker/Abuse Coordinator depending on who got to the facility first, the others would just see who did what and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible for the decision to determine if a staff member had committed an abusive act toward a resident, and made decisions regarding all disciplinary action. Review of the facility's policy revealed only the Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Administrator #1 stated in an interview conducted on 02/28/13 at 5:20 PM that his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. According to Administrator #1 when he interviewed LPN #1, she did confirm Resident #1 was crying and yelling at the Nurses' station and she (the Charge Nurse) instructed staff to leave the resident up in the chair, but explained that it was to observe the resident. Administrator #1 also acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson. Additionally, the Abuse Coordinator had reported that although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition, an alert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously an aiert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously. However, after considering all the information that had been obtained during the investigation, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1, and therefore unsubstantiated the allegation, and took no further disciplinary action against LPN #1 in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee #I in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. At the time of the investigation, LPN #1, the Charge Nurse, was no longer employed by the facility, and attempts to interview her were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #29 no 03/18/10 with [DIAGNOSES REDACTED]. A list of residents assessed by the facility to be alert, oriented and interviewable was provided on 04/02/13. According to the list, the facility had assessed Resident #29 to be alert, oriented, and interviewable. Resident #29 was observed sitting in a wheelchair in the facility dining room on 04/05/13 at 5:50 PM.

Interview conducted on 04/05/13, at 5:50 PM with Resident #29 revealed he/she was afraid of a staff person (SRNA #14). The resident stated SRNA #14 had touched his/her breast when the SRNA hugged the resident approximately 2-3 months ago, and would come into the resident's room without knocking when the resident was disrobed. Resident #29 stated he/she reported the incident that occurred 2-3 months ago to the facility's Social Worker/Abuse Coordinator at the time the incident to cocurred. The resident stated SRNA #14 had been moved to another area in the facility after he/she reported the incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had touched the resident's breast and, although Resident #29 reportedly did not feel SRNA #14's action was abuse, the resident felt the his actions were inappropriate. According to the Social Worker/Abuse Coordinator, she had the responsibility to investigate allegations of abuse, to report the allegation to the appropriate state agencies, and to provide administrative staff a report of her findings. The Social Worker/A worker/Abuse Coordinator stated she obtained verbal statements from Resident #29; Resident #29; Radignter; and SRNA and a written statement from a staff Nurse that had been assigned to the Seasons unit at the time the resident reported the incident. The Social Worker/Abuse Coordinator stated as a result of the allegation made by Resident #29, SRNA #14 was reassigned to another unit of the facility and was permitted to continue to provide direct care to residents. In addition, the Social Worker/Abuse Coordinator stated she had not considered the incident to be possible abuse; did not conduct

Facility ID: 185337

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:3/30/2014

| LEE COUNTY CARE & REF | ABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
|------------------------------|---------------------------------|--|---|------------------------------------|
| NAME OF PROVIDER OF SU | PPLIER | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| | 185337 | | | |
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | B. WING | | 04/09/2013 |
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCT A. BUILDING | TION | (X3) DATE SURVEY COMPLETED |
| CENTERS FOR MEDICARE & | & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

F 0225

(continued... from page 17)
further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the Social Worker/Abuse Coordinator, as part of her responsibilities of abuse investigations, she was responsible to remove the alleged perpetrator from resident care and to provide administrative staff the results of her investigation. Administrator #1 was no longer employed as Administrator of the facility and an interview could not be obtained with Administrator #1. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not aware of the incident involving Resident #29, he would attempt to locate the facility's investigation. Continued interview with the Vice President of Operations on 04/05/13 at 7:30 PM revealed SRNA #14 had continued to work at the facility and was working on 04/05/13 when Resident #29 reported the incident to the surveyor. According to the Vice President of Operations, the facility's investigation of the incident consisted of the interviews that had been obtained by the Social Worker/Abuse Coordinator. The Vice President of Operations stated effective 04/05/13 SRNA #14 had been suspended from employment pending further investigation of the incident. The Vice President of Operations stated he did recall Administrator #1 telling him SRNA #14 had been moved to another area of the facility to work due to a resident telling staff he/she did not want SRNA #14 providing their care. However, the Vice President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. According to investigation witness statements and an investigation was started on 03/22/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident. Additional review on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the appropriate State Agencies until 04/09/13, sixteen (16) days after the alleged incident was reported. In addition, there was no evidence the alleged perpetrator had been suspended. However, the facility's policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and erievances presented to them: and that the resident was to receive measures to ensure his or her immediate safety and Administrator/locasinee would make an reasonator entors to investigate and address after a larged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the initial report of the allegation dated 04/09/13, revealed that SRNA #13 was not on duty, the facility had attempted to contact SRNA #13, and SRNA #13 would be suspended and not allowed to work until the investigation had cleared the SRNA of the allegation. A review of the facility's investigation log revealed no entry regarding Resident #30. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed, on 04/08/13, the Social Worker/Abuse Coordinator informed the Administrator of the allegation of abuse that had occurred on 03/22/13 and involved Resident #30. According to the Social Worker/Abuse Coordinator, it was the Social Worker/Abuse Coordinator's responsibility to report the allegation to the Worker/Abuse Coordinator is twas the Social Worker/Abuse Coordinator is responsibility to report the allegation to the Administrator and the Director of Nursing. In addition, the Social Worker/Abuse Coordinator stated, the facility's investigation of the allegation that had reportedly occurred on 03/22/13 had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talking with Resident #30 on 03/24/13, however, was not aware of an abuse allegation. According to Administrator #2 he was not aware of the allegation of abuse had not been thoroughly investigated and reported as required until the investigation file was found on 04/08/13. 4. Interview with facility Administrator #2 on 03/28/13 at 1:50 PM revealed there had been an was found in 24/08/13. 4. interview with facility Administration #2 on 03/28/13 at 11.97 Mi revealed there had been an allegation of abuse that he planned to report to the appropriate State Agencies. Administrator #2 stated the incident occurred on 03/24/13, was reported on 03/27/13, and the facility was in the process of conducting an investigation. According to Administrator #2, a resident said a Nurse was mean to her/him, but no abuse occurred. Administrator #2 further stated the DON was aware of the allegation on 03/24/13, the date of the alleged abuse, and confirmed an investigation of the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was mean to the resident and the resident did not want the Nurse to provide exercise the resident and the resident did not want the Nurse to provide exercise the resident and the resident and the resident did not want the Nurse to provide exercise the resident and the resident of the reported to one was the provide exercise the resident and the resident of the reported to one was the resident and the resident of the reported to one was the resident and the resident of the reported to one was the resident and the resident of the reported to one of the resident and t provide care for her/him. According to the investigation Resident #8 was interviewed on 03/28/13, and reported no one was mean to her/him. The investigation also revealed the resident reported one of the women was mean to her, and stated it was RN #8; however, documentation in the report revealed the resident stated he/she didn't really mean it. Further review of the investigation revealed RN #8 verified Resident #4 had told her that she was mean to the resident on 03/24/13. Based on the investigation revealed RN #8 verified Resident #4 had told left that sie was filean to the resident on 05/24/15. Based on the facility's investigation the facility unsubstantiated abuse based on the resident's moderately impaired cognitive ability. Review of Resident #4's medical record revealed on 02/01/13 the facility assessed the resident's cognition level as moderately impaired when a significant change in status Minimum Data Set (MDS) assessment had been completed. Interview with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she needed to go to the restroom during the night and turned the call light on to alert staff. Resident #4 stated he/she could not wait and went to the restroom alone. According to Resident #4, RN #8 can in and started telling the resident not to get up unassisted and to wait for help. Resident #4 stated RN #8 was being loud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not wait the RN to provide care for him/her; and, not to come back into the resident's room. Resident #4 stated that later in the morning, he/she told RN #8 that he/she was sorry and the resident did not think the RN was mean. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on 03/24/13, around midnight, Resident #4 rang the call light and the RN went into the room. The RN found the resident in the restroom and instructed the resident to wait for assistance before getting up. According to the RN, the resident became angry and upset and yelled at the RN don't fuss, don't quarrel. RN #8 further stated she went into Resident #8's room again between 2:00 AM and 4:00 AM when the resident's call light was sounding and the resident told the RN he/she did not want the RN to take care of her/him anymore, and stated they could not get along and the resident did not want the Nurse coming in the resident's room anymore. RN #8 further stated around 6:00 AM on 03/24/13 Resident #4 told her she could provide care for her and the resident did not think the RN was mean. Further interview revealed the RN had informed in a casual way RN #9 on B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 around 6:00 PM the DON called and asked the RN to come in early for work. RN #8 stated when she arrived, the DON asked her about the incident on 03/24/13. RN #8 stated she explained the incident and the DON informed her it should have been reported to the DON and Administrator as an allegation of abuse. RN #8 stated after speaking with the DON on 03/27/13 she went out on the floor and worked her twelve (12) hours scheduled shift. Interview with RN #9 on 03/29/13 at 8:02 PM revealed he did remember RN #8 coming to B wing on the morning of 03/24/13 crying. However, he did not remember anything related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, RN and 100 AM, RN and related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, R #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report the information to the DON or Administrator as she had been instructed to. Interview with RN #4 on 03/29/13 at 7:35 PM revealed she worked on the morning of 03/24/13. According to RN #4, RN #8 informed her during change of shift of the incident between the RN and Resident #8. RN #4 stated RN #8 informed her she had documented the incident in the resident's Nurse's Notes and did not know what else to do about it. RN #4 further stated around 9:00 AM on 03/24/13 she reported the incident to the Weekend Manager because it was charted in the Nurse's Notes; in case there was a need to open an investigation. RN #4 went on to state if it had not been charted she wouldn't have been so concerned about reporting it. Further interview ## went on to state if it had not been charted she wouldn't have been so concerned about reporting it. Further interview revealed RN #4 did not report the incident to the DON or Administrator because she didn't see any immediate harm. RN #4 stated she didn't feel abuse occurred, since the resident was fine, everything was fine, and since RN #8 did not go back into Resident #4's room. Interview with the Weekend Manager, who was the Dietary Manager, on 03/28/13 at 6:41 PM, revealed she was the Manager on Duty on Sunday 03/24/13. When she came in that morning she went to each Nurse's station to talk with Nurses. According to the Weekend Manager, RN #4 informed her of the incident that transpired between RN #8 and Resident #4

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Previous Versions Obsolete Page 18 of 59

PRINTED:3/30/2014

| CENTERS FOR MEDICARE & | & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|---|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTA. BUILDINGB. WING | FION | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF SUI LEE COUNTY CARE & REH | | | STREET ADDRESS, CITY, STA 246 EAST MAIN STREET | ATE, ZIP |
| For information on the nursing | home's plan to correct this deficien | cv_please contact the nursing hor | me or the state survey agency | |
| (X4) ID PREFIX TAG | • | DEFICIENCIES (EACH DEFICIA | ENCY MUST BE PRECEDED BY | Y FULL REGULATORY |
| F 0225 | incident. The Weekend Manager #8 she did not think the RN was the DON, nor did she report the i was aware of the incident betwee informed her of the situation on C DON did not initiate an investiga Consultant contacted her regarding she called RN #8 and asked her tallowed the RN to continue work initiated on 03/27/13. The DON occurred. Interview with the Coo another corporate staff member v Consultant, the trainee was review between the resident and RN #8. was aware of the incident. The D The Cooperate Nurse Consultant Chief Nurse Executive informed interview had been conducted, sheer protected. The Cooperate Nevening of 03/27/13. Interview wo 03/27/13 concerning the incident statement from the RN and that s President of Operations was awarthis is not good, and stated she whought they needed to suspend the Cooperate Regional Controller of the incident between Resident #4 the Administrator. Further intervibecause, at that point, the investigation; the DON called R1 although he sat in during the intewas permitted to work after being facility's abuse policy revealed the following the incident and during Worker would make any immedirelated to the alleged or suspected legation) was reportable, he stalere, I just didn't feel it was true allegation) was reportable, he stalere, I just didn't feel it was true allegation) was reportable, he stalere, I just didn't feel it was true allegation) was reportable, he stalere, I just didn't feel it was true allegation was reportable, he stalere, I just didn't feel it was true. | stated the DON told her the way- mean. The Weekend Manager stan ncident to the Administrator. Inte n Resident #4 and RN #8 that hac 3/24/13 and she did not give the tion nor did she notify the Admin ng the incident after she had read to come to the facility for interviewing stated after she and Administrator perate Nurse Consultant on 03/28 while performing audits of residen wing Resident #4's chart and disco Further interview revealed she ca ON informed her she was, but has stated on 03/27/13 she called the her to interview RN #8 and obtain the did not conduct a follow-up to o urse Consultant stated she was no ith the Chief Nurse Executive on between RN #8 and Resident #4. the would notify the Cooperate Re y. Further interview revealed she ould notify the Administrator. Act he would notify the Administrator. Act he would notify the Roperated she suntangle she was not aware Re gatton had just been initiated. Inte 5 AM and 4:11 PM, revealed he the DON regarding the incident. A gration and failed to initiate an im he DON acknowledged the incide the Birth of the shall be a shalf paying attentio g interviewed on 03/27/13 while the resident was to receive measure the investigation process. The A ate decisions related to the remov the down. He att of hearts I have ga and reportable. He stated as of 03. | the DON around 10:00 AM on 03 the situation was handled was fine ted she did not pursue an investigar view with the DON on 04/02/13 of occurred on 03/24/13. She stated Weekend Manager any further insinstrator. The DON stated on 03/27 it in the Nurse's Notes. The DON w. The DON further stated she and gher and prior to the finishing the #2 interviewed RN #8, they deter #1 interviewed RN #8, they deter with the finishing the provided for the provided for the finishing the provided for finishing the finishing the finishing the provided for finishing the finis | since Resident #4 told RN tition after speaking with at 8:45 PM revealed she the Weekend Manager had tructions. However, the 7/13, the Corporate Nurse stated, at that time, I Administrator #2 investigation that was mined abuse had not 13 she was training e Corporate Nurse 13 regarding the incident ding, to question if she boort it to anyone else. He findings. The wealed, after the initiated and residents work the shift on the did receive a call on see Consultant to obtain a rge while the Vice Controller who stated ive, even though she terview with the Chief Nurse Executive of tive that she would notify e evening of 03/27/13 3/28/13 at 2:00 PM; 3/27/13 at approximately DON informed him she had nistrator #2 to conduct an rator #2 stated he was aware the RN lowever, review of the afety and well-being using and/or Social giving or direct contact think it (the) while I've been |
| F 0226 | determined the facility failed to h implemented for six of twenty-ni suspicion of an incident of abuse for an alleged incident of abuse of abuse and during the investiga On 02/17/13, facility staff witnes approximately 7:35 AM. Staff att Coordinator to report the allegati staff left a voice message on the 1 the Staff Development Coordinat staff observed the abuse. After re protected from potential further a Nursing (DON) and/or Social We alleged abuser from direct care gi on the floor with residents during talked with the other staff, and at Nurse Consultant on what action after staff observed the abuse. Af the investigation, interviews, and had occurred and the allegation o record review revealed LPN #1 d falsification of documentation. (f failed to immediately initiate an i during an investigation, and faile abuse involving Residents #4, #1 in place to ensure the developme was likely to cause, serious injury were identified on 03/01/13 and 0 determined to exist on 02/17/13 a notified of the Immediate Jeopar 04/22-04/23/13, as alleged in the Facility Practices F226 - S/S E, w effectiveness of systemic change policy, dated 01/2012, revealed, and the Administrator, Director o charge nurse who receives the re immediately reported to the char investigation was to be initiated i | N, and a review of the facility's potative an effective system to ensure ne residents (Residents #1, #4, #1 was reported immediately, failed wolving a staff member, and faile tion process. Facility staff failed sed Licensed Practical Nurse (LP rempted, between 11:30 AM and on per the facility's policy. The Scocial Worker/Abuse Coordinator or/Nurse Manager on 02/17/13, a ceipt of the report of alleged abus buse. The facility's policies and porter were the staff that could materially staff that could materially that the staff that could materially the staff that could materially that the staff that could materially staff that could materially staff that the staff that could materially sta | | bluse were failed to ensure a attion was conducted ed following a report is reported timely. abuse Resident #1 at Social Worker/Abuse was unavailable and egation of abuse to kimately four hours after lents were rand/or Director of d to the removal of the lent care and remained ed the investigation, the DON, and the proximately five hours red as a result of inclusion that abuse ver, interview and D2/25/13 related to evealed the facility potential abuse egations of potential an effective system is from abuse caused, or Jeopardy situations d Quality of Care was actices. The facility was mediate Jeopardy was with the facility alleging of the Immediate Jeopardy on Resident Behavior and monitors the he facility's abuse ly to the charge nurse, ed immediately by the of abuse was to be revealed at horough eres, residents, |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11 If continuation sheet Page 19 of 59 Facility ID: 185337

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
|---|---|---|---|
| NAME OF PROVIDER OF SU LEE COUNTY CARE & REF | | 246 EAST M | DRESS, CITY, STATE, ZIP AIN STREET LLE, KY 41311 |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home or the state | survey agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIENCY MUST I MATION) | BE PRECEDED BY FULL REGULATORY |
| | SUMMARY STATEMENT OF IOR LSC IDENTIFYING INFORIOR LSC IDENTIFYING INFORIOR (continued from page 19) efforts to investigate and address to receive measures to ensure his process. The policy further stated related to the removal of individual 1. A review of the facility's invesput to bed. However, based on dethe resident to bed due to the resisuspended on 02/17/13 pending tinterviewed, and one resident repfacility. According to the investig the course of the investigation, at by the facility and attempts to conterminated from employment by: Development Coordinator/Unit Macility on [DATE] at approximal and the LPN refused to Worker/Abuse Coordinator prior Manager stated after the housekeindividuals on the unit, and had the LPN address atted LPN #1 remained on the mistated she did not remove LPN #her to pull the LPN from the floo Coordinator, for further guidance the Staff Development Coordinat and informed LPN #1 that she we she could remove staff from the floo Coordinator, for further guidance the Staff Development Coordinat and informed LPN #1 that she we she could remove staff from the Further interview revealed she we facility's policy revealed any repethe Administrator, Director of Nucharge nurse who receives the reper the Administrator, Director of Nucharge nurse who receives the reper the remediate safety and wellbeir ecord review revealed these proo 02/28/13 at 4:53 PM confirmed so Development Coordinator/Nurse investigation. For the rimediate safety and wellbeir ecord review revealed these proo 02/28/13 at 4:53 PM confirmed so Development Coordinator/Nurse investigation. For the rimediate safety and wellbeir ecord review revealed these proo 02/28/13 at 4:53 PM confirmed so Development Coordinator/Nurse investigation. For the rimediate development Coordinator for well and the facility was not aware the facility was not aware the facility and the facility was not aware the facility and the facility and the facility of the fac | alleged reports, concerns, and grievances preser or her immediate safety and wellbeing following the Administrator and/or DON and/or Social Wals from direct care giving or direct contact relatigation revealed on 02/17/13, staff reported Resecumentation, staff reported LPM #1 (who was the dent yelling and crying. The investigation further duttome of the investigation. Further, during orted he/she had overheard LPN #1 say negative ation, dated 02/22/13, the facility did not substatempts were made to contact LPN #1 for intervitiant the LPN were unsuccessful. A review of LI the facility on 02/28/13 at 5:35 PM and again on 03 ely 11:00 AM to do a weekend check. At approximate the LPN were unsuccessful. A review of LI the facility for put the resident to bed and that the notory of the person of | ated to them; and that the resident was g the incident and during the investigation or orker would make any immediate decisions ted to the alleged or suspected abuse. ident #1 was crying, and wanted to be the Charge Nurse) would not allow staff to put it revealed the LPN was immediately the investigation, other residents were things about another resident at the intatie that the abuse occurred. During ew. However, LPN #1 was no longer employed PN #1's employee file revealed the LPN was mentation. Interview with the Staff work at 11:07 AM revealed she came to the simal that the staff work at 11:20 AM 11:40 AM, Housekeepers #1 wey had witnessed between LPN #1 and (excepers informed her Resident #1 asked to be key had attempted to contact the Social yet. The Staff Development Coordinator/Unit tarted an investigation, talked to e spoke with Stafe Registered Nurse fif Development Coordinator/Unit Manager she initiated the investigation. She with the trivial point of the call the Social Worker/Abuse e to contact her via phone. According to 's Nurse Consultant for further direction, some She further stated she did not know if emove facility staff from the floor. ekcepers was abuse. However, review of the limmediately to the charge nurse, and were to be notified immediately by the as to receive measures to ensure his or gation process. However, interview and the Social Worker/Abuse Coordinator on of the facility housekeepers and the Staff e facility is a worker/Abuse Coordinator on of the facility housekeepers and the Staff e facility is the went an allegation of aff training records revealed the last ministrator #1 on 02/28/13 at 5:20 PM, ed the LPN since she was loud by nature. At the conclusion of the investigation, diministrator #1 on 02/28/13 at 5:20 PM, ed the LPN since she was loud by nature. At the conclusion of the investigation of aff training records revealed the last ministrator #1 on 02/28/13 at 5:20 PM, ed the LPN since she was loud by nature. At the conclusion of abuse was made. Per nediately remove the |
| FORM CMS-2567(02-99) | Event ID: YL1011 | ility. According to the initial report, dated 04/09 Facility ID: 185337 | If continuation sheet |

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

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (continued... from page 20)
contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was not aware the allegation of abuse had not been thoroughly investigated and reported as required until the Social Worker/Abuse Coordinator had reported on 04/08/13 that the investigation was not complete. At the time of the interview, Administrator #2 could provide no documentation that any action had taken to ensure residents were protected during the facility's investigation or that the allegation had been reported to the appropriate State Agencies. According to Administrator #2, the allegations were logged in an abuse investigation log at the end of each day. However, review of the facility's investigation log revealed no entry regarding Resident #30. 4. A review of the facility's investigation dated 04/01/13 revealed on 03/27/13, the Administrator was informed that Resident #4 had made an allegation of abuse on 03/24/13, three days prior. According to the investigation, Resident #4 was interviewed on 03/28/13 and reported that no one had been mean to (her/him). When the facility questioned the resident if he/she had alleged someone was mean to him/her the resident stated he/she had told one of the women that. According to the facility's investigation, the resident stated he/she had told one of the women that Resident #4 woman was RN #8 and the resident stated, Yeah my little nurse. Further review of the investigation revealed RN #8 stated Resident #4 did make the statement on 03/24/13 that she was mean t F 0226 reported she had told the resident to use the call light for assistance instead of getting up on her own. All residents assessed by the facility to be interviewable were interviewed in regards to their treatment. The investigation concluded assessed by the facility to be interviewable were interviewed in regards to their treatment. The investigation concluded the allegation of abuse was unsubstantiated based on Resident #4's moderately impaired cognitive ability. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on the morning of 03/24/13 Resident #4 alleged the RN was mean to the resident and Resident #4 did not want RN #8 to come into the resident's room again or provide care for the resident. RN #8 stated she documented the incident in the nurse's notes, and only thought Resident #4 was upset the morning of 03/24/13. However, RN #8 stated she should have told another nurse; removed herself from the floor; and called the Administrator and DON. RN #8 stated the incident didn't seem like an allegation of abuse. Interview with the DON on 04/02/13 at 8:45 PM revealed she was informed of the allegation against RN #8 on 03/24/13 by the Weekend Manager. She stated she did not give the Weekend Manager any further instructions. The DON stated on 03/25/13 she interviewed Resident #4; got side tracked with something else; and did not notify the Administrator or interview RN #8. The DON stated on 03/27/13, the Corporate Nurse Consultant questioned her related to a nurse's note found in Resident #4's medical record related to the incident. The DON stated she called RN #8 and had her come in to work early on the evening of 03/27/13 to obtain an interview. After interviewing the nurse, the DON and Administrator #2 allowed RN #8 to work her scheduled 12-hour shift. The DON stated since RN #8 and Resident #4 denied the allegation, she and Administrator #2 decided abuse did not occur. However, the DON acknowledged the nurse, the DON and Administrator #2 allowed RN #8 to work her scheduled 12-hour shift. The DON stated since RN #8 and Resident #4 denied the allegation, she and Administrator #2 decided abuse did not occur. However, the DON acknowledged the facility's investigation had not been finished at the time of the interview. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM revealed he became aware of the incident on 03/27/13, at approximately 5:40 PM, and spoke to the DON regarding the incident. Administrator #2 stated the DON informed him she had forgotten to inform him of the allegation of abuse and failed to initiate an investigation related to the allegation. Further, Administrator #2 stated he sat in during the interview between the DON and RN #8; however, he was half paying attention. Administrator #2 initially stated in interview that he was not aware RN #8 had been permitted to work on 03/27/13 and that he didn't ask (DON) why she didn't remove the alleged perpetrator. Continued interview with Administrator #2 revealed he was aware RN #8 had been permitted to work after the interview had been conducted on 03/27/13 while the investigation was in progress. Interview further revealed Administrator #2 did not think it was reportable and stated, In investigation was in progress. Interview further revealed Administrator #2 did not think it was reportable and stated, In my heart of hearts I have gotten to know the little girl while I've been here, I just didn't feel it was true and reportable. Further interview revealed Administrator #2 had not interviewed the DON regarding the incident and stated the DON had just forgotten to do anything with the information she received on 03/24/13. Administrator #2 stated RN #8 should have reported the incident to another Charge Nurse on 03/24/13; that he should have been notified of the incident; and, that RN #8 should have been sent home on 03/24/13 following the incident. Continued interview with Administrator #2 on 03/29/13 at 4:11 PM revealed he did concur with the DON on 03/27/13 related to allowing RN #8 to work her shift after the resident stated he/she did not want RN #8 to take care of her. Per interview, he and the DON agreed RN #8 could continue to provide resident care. Administrator #2 further stated in hindsight with the facility he way it is right now allowing the RN to continue to work during the investigation was probably a bad decision. 5. Review of the facility's investigation revealed SRNA #1 and SRNA #8 reported to the facility's Social Worker/Abuse Coordinator that on 04/04/13, they overheard a Lab Technician tell Resident #19 It's going to hurt you worse than it will me because I have a needle stuck in your arm. Even though the investigation revealed the incident had been reported immediately reported to the required state Coordinator on 04/04/13, the facility failed to ensure the allegation was immediately reported to the required state Coordinator on 04/04/13, the facility failed to ensure the allegation was immediately reported to the required state agencies until 04/06/13 (two days after the incident was reported). Interview on 04/09/13 at 2:55 PM with the Corporate Nurse Executive who had completed the investigation of the allegation revealed she initially had not considered the allegation reportable. However, the Corporate Nurse Executive stated as a part of the facility's ongoing audits, the Nurse Executive who had completed the investigation of the allegation revealed she initially had not considered the allegation reportable. However, the Corporate Nurse Executive stated as a part of the facility's ongoing audits, the allegation was determined to be an allegation of verbal abuse and was reported to the appropriate State Agencies late, on 04/06/13. The Corporate Nurse Executive stated the allegation being reported late was better than not reporting the allegation. 6. An interview conducted with the facility's Social Worker/Abuse Coordinator no 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13 of an abuse allegation involving Resident #31 but she could not recall the date of the allegation. An interview with Administrator #2 on 04/08/13 and an investigation of the allegation had not been initiated. Continued interview with Administrator #2 on 04/08/13 and an investigation of the allegation had not been initiated. Continued interview with Administrator #2 on 04/09/13 at 5:00 PM revealed Administrator #2 had discussed the allegation reported by the Social Worker/Abuse Coordinator on 04/08/13 with staff and learned there was an allegation that Resident #31 may have been sat down in a chair too hard by facility staff around 3/17-19/13, but no witness statements or investigation could be found. Review of the facility's investigation log revealed no entry regarding the alleged incident involving Resident #31, which was reported on 04/08/13. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: The Interim Social Services Director (SSD) completed an interview with Resident #31 and the resident's daughter on 04/09/13. The facility suspended the alleged perpetrator on 04/09/13. Other employees were interviewed by the Vice President of Human Resources and the Regional Human Resources Director on 04/10/13 to identify if any other staff had observed the allegad perp reported to the appropriate State Agencies on 04/09/13 by Administrator #2. The Administrator and the Interim Social Services Director interviewed Resident #30 on 04/10/13 regarding the alleged abuse incident. Statements were obtained on 04/10/13 from the two staff who was the alleged perpetrators. The two alleged perpetrators were suspended on 04/10/13. An interview was completed by the Chief Operating Officer on 04/09/13 with the Nurse who provided care for Resident #30 on the evening of the alleged incident. Interviews were completed by Regional Staff on 04/09/13 with other residents who reside on the same unit as Resident #30, regarding staff treatment during care, with no concerns identified. The allegation of abuse against Resident #29 was reported to the appropriate State Agencies on 04/05/13 by the Chief Nurse Executive. Administrator #2 and the Interim Social Services Director interviewed Resident #29 on 04/05/13 regarding the alleged abuse. The Regional Nurse completed a body audit on Resident #29 on 04/05/13 with no injuries identified. The alleged perpetrator was interviewed by the Vice President of Human Resources and the Chief Operating Officer along with a statement obtained. The alleged perpetrator was suspended on 04/05/13 along with Administrator #1, who was the facility 's Administrator at the time of the occurrence, Resident 's with a BIMS score over 7 was interviewed by Department Managers on 04/05/13 and Regional Staff on 04/05/13 regarding other incidents of inappropriate treatments, with no concerns identified. The

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Previous Versions Obsolete Page 21 of 59

PRINTED:3/30/2014

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0226 (continued... from page 21) allegation of abuse by Resident #4 was reported to the appropriate State Agencies on 03/30/13 by Administrator #2 and a final report was submitted on 04/03/13 to the appropriate State Agencies, which unsubstantiated abuse regarding Resident #4. The second allegation of abuse by Resident #4 was submitted to the appropriate State Agencies on 04/09/13. The staff member who was the alleged abuser was suspended during the investigation. A third allegation by Resident #4 was submitted on 04/09/13 regarding a review of an incident report dated 03/28/13 for bruises. The investigation was in progress. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a posttest. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed, will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse to include investigation, reporting, and protection. The Independent Contractor Team on 04/12/13. Staff not scheduled, on leave or who work as needed, will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Independent Contractor initiated continued abuse education regarding identifying, reporting, and ensuring resident safety on 04/11/13. All staff scheduled to work will receive this re-education by 04/12/13. Staff not scheduled to work during that time frame, who work as needed, or who are on leave of absence will receive the education upon returning to work, by Administrator #2, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Staff Development Coordinator, or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or above to determine their feelings of safety and identify any allegations of mistreatment or abuse. There were no concerns voiced. A body audit was complete for eighty-one (81) residents, there were an additional nine (9) residents who refused a body audit therefore the audit was not performed on those nine (9), by Administrative Nurses (MDS Coordinators, DON, Staff Development Coordinator), on 04/12/13 and regional nurses (Signature Care Consultants, Internal Audit Director -RN from the Corporate office, Director of Medical Review-RN from the corporate office) for residents with a BIMS score below 7 to ensure that no physical signs and symptoms of abuse were present. Results of body audit did not reflect any p Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin.

The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assist F 0226 Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility's policy and procedures and investigations, it was determined the facility failed to have an effective system to ensure policy and procedures related to abuse were implemented for six of twenty-nine residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to ensure a implemented for six of twenty-nine residents (Residents # 1, # 4, # 19, # 29, # 20, and # 31). The facility failed to ensure as suspicion of abuse was reported immediately, failed to ensure residents were protected following a report of abuse and during the investigation process. Facility staff failed to ensure an allegation of abuse are protected following a report of abuse and during the investigation process. Facility staff failed to ensure an allegation of abuse are propred timely. On 02/17/13. facility staff witnessed Licensed Practical Nurse (LPN) # 1, the Charge Nurse, verbally abuse Resident # 1 approximately 7:35 AM. Staff attempted, between 11:30 AM and 12:00 PM, to contact the facility's Social Worker/Abuse Coordinator to report the allegation per the facility's policy. The Social Worker/Abuse Coordinator or season of a social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 1:40 AM, approximately four hours after staff observed the abuse. After receipt of the report of alleged abuse, the facility failed to ensure residents were protected from potential further abuse. The facility's policies and procedures stated the Administrator and/or Director of Nursing (DON) and/or Social Worker were the staff that could make any immediate decisions related to the removal of the alleged abuse from direct care giving. Interviews revealed LPN # 1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, the DON, and the Nurse Consultant on what action to take. LPN # 1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. After completion of the facility is investigation, and the consultance of the staff of the surface of the staff of the s suspicion of an incident of abuse was reported immediately, failed to ensure that a thorough investigation was conducted for an alleged incident of abuse involving a staff member, and failed to ensure residents were protected following a report

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION) CLIA IDENNTIFICATION À. BUILDING B. WING ____ 04/09/2013 NUMBER 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0226 (continued... from page '22)

1. A review of the facility's investigation revealed on 02/17/13, staff reported Resident #1 was crying, and wanted to be put to bed. However, based on documentation, staff reported LPN #1 (who was the Charge Nurse) would not allow staff to put the resident to bed due to the resident yelling and crying. The investigation further revealed the LPN was immediately suspended on 02/17/13 pending the outcome of the investigation. Further, during the investigation, other residents were interviewed, and one resident reported he/she had overheard LPN #1 say negative things about another resident at the facility. According to the investigation, dated 02/22/13, the facility did not substantiate that the abuse occurred. During the course of the investigation, attempts were made to contact LPN #1 for interview. However, LPN #1 was no longer employed by the facility and attempts the contact the LPN were unsuccessful. A reviewed IPN #1 for interview. by the facility and attempts to contact the LPN were unsuccessful. A review of LPN #1 was no longer employed by the facility and attempts to contact the LPN were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from employment by the facility on 02/25/13 for falsification of documentation. Interview with the Staff Development Coordinator/Unit Manager on 02/28/13 at 5:35 PM and again on 03/04/13 at 11:07 AM revealed she came to the facility on [DATE] at approximately 11:00 AM to do a weekend check. At approximately 11:30 AM-11:40 AM, Housekeepers #1 #2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be put to bed and the LPN refused to allow staff to put the resident to bed and that they had attempted to contact the Social Worker/Abuse Coordinator prior to notifying her in accordance with facility policy. The Staff Development Coordinator/Unit Manager stated after the housekeepers spoke with her she went out on the floor, started an investigation, talked to individuals on the unit, and had the staff fill out written statements. She stated she spoke with State Registered Nurse Aides and an Activities Worker and had them fill out witness statements. The Staff Development Coordinator/Unit Manager stated LPN #1 remained on the nursing unit at the nurses' station during the time she initiated the investigation. She stated she did not remove LPN #1 from the floor immediately because she was trying to determine if it was appropriate for her to pull the LPN from the floor. Between 11:30 AM and 12:30 PM she attempted to call the Social Worker/Abuse Coordinator, for further guidance, per the facility policy; however, she was unable to contact her via phone. According to the Staff Development Coordinator/Unit Manager, she then contacted the Facility's Nurse Consultant for further direction, and informed LPN #1 that she was being sent home pending the final investigation. She further stated she did not know if she could remove staff from the floor, and the allegation had to be justifiable to remove facility staff from the floor. Further interview revealed she was not sure what was being reported by the housekeepers was abuse. However, review of the facility's policy revealed any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the ch #2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and ner immediate safety and welloeing following the incident and during the investigation process. However, interview and record review revealed these procedures were not implemented. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM confirmed she had received a voice mail message from one of the facility housekeepers and the Staff Development Coordinator/Nurse Manager on 02/17/13. She stated she came to the facility the same day and assisted with the investigation. Further interview with the Social Worker/Abuse Coordinator on 03/04/13, at 1:25 PM, revealed staff had been trained to report allegations of abuse to her, the DON or the Administrator. The Social Worker/Abuse Coordinator further stated she was not sure if a nurse could remove a staff member from direct resident care in the event an allegation of abuse had been made and staff could not reach Administrative staff. Review of staff training records revealed the last abuse training provided by the facility was in December 2012. Interview with Administrator #1 on 02/28/13 at 5:20 PM, revealed LPN #1 did not have a history of abuse and staff may have misinterpreted the LPN since she was loud by nature. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation, and the facility was not able to substantiate that abuse occurred. Interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social Worker/Abuse Coordinator prior to the removal of the alleged perpetrator after an allegation of abuse was made. Per interview, he was not aware the facility's abuse policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, review of the facility's policy revealed only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Interview with the facility's Vice President of Operations, Chief Nurse Executive, and the Nurse Consultant on 03/04/13 at 5:05 PM, revealed the facility's abuse policy had been developed at the corporate level and they were not aware the policy indicated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact following an allegation of suspected abuse. 2. Interview with Resident #29 on 04/05/13 at 5:50 PM, revealed the resident reported he/she was afraid of SRNA #14 because he had touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the incident to the facility's Social Worker/Abuse Coordinator. Interview with the Social Worker/Abuse Coordinator on 04/05/13, at 3:30 PM, revealed she also acted as the facility's Abuse Coordinator, was responsible to assist with investigations related to abuse/neglect, and to provide staff education/in-service related to abuse/neglect as indicated. The Social Worker/Abuse Coordinator stated in accordance with facility policy allegations of alleged abuse were to be immediately investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator further stated she had investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator Infinite stated site had received training from the facility regarding the facility's abuse policies/procedures when she was hired by the facility on 06/20/11, as well as when the policy, which included reporting, investigation, and resident protection of abuse allegations, was revised in March 2013. Further interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she and Administrator #1 talked with the resident about the incident and the resident stated he/she felt the touching incident was imappropriate. The Social Worker/Abuse Coordinator further stated Resident #29 told be before the first properties of the Social Worker/Abuse Coordinator further stated Paging to the Social W her he/she did not feel the incident was abuse. According to the Social Worker/Abuse Coordinator, SRNA #14 was moved to another unit in the facility following the report by Resident #29 and was allowed to continue to provide direct care for residents. Although the Social Worker/Abuse Coordinator stated she did obtain statements from Resident #29, the resident's daughter, SRNA #14, and a staff nurse assigned to the Seasons Unit, she did not further investigate the alleged incident. The Social Worker/Abuse Coordinator also stated since the resident stated she did not feel the incident was abuse, she did not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the Social Worker/Abuse Coordinator revealed she was no longer employed by the facility effective 04/08/13 due to illness. During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or Administrator; and they would direct her on the procedures to follow when an allegation of abuse was reported, including investigation, protection, and reporting. The Social Worker/Abuse Coordinator stated she had missed doing some things during the investigation of the incident reported by Resident #29. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was currently acting as the facility's Administrator, and was not aware of the incident involving Resident #29. Further interview with the Vice President of Operations on 04/05/13 at 7:30 PM, revealed SRNA #14 continued to work at the facility in the provision of direct care after Resident #29 had reported the incident and was still providing direct resident care on 04/05/13. However, the Vice President of Operations stated SRNA #14 was suspended from employment after he was informed of the alleged incident on 04/05/13. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and he could provide no evidence the allegation had been reported to the state agencies as directed by the facility's abuse policy. 3. Review of the facility's investigation, initiated by the facility's Social Worker/Abuse Coordinator on 03/24/13, revealed Resident #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while in the shower and had wrapped a sheet too tight around the resident's neck. Continued review revealed the investigation was not completed and the allegation was not reported to the appropriate state agencies until 04/09/13, (sixteen days after the incident was reported). It could not be determined by a review of documentation if the facility had protected residents incident was reported). It could not be determined by a review of documentation if the facility had protected residents from further potential abuse while the investigation was being conducted, or if the facility allowed SRNA #13 to continue to provide resident care at the facility. According to the initial report, dated 04/09/13, the facility had attempted to contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that open and the social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that open and the social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, the investigation of the allegation had been been part of the property of t

that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not

Facility ID: 185337

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:3/30/2014

| CENTERS FOR MEDICARE | & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|---|---|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SU LEE COUNTY CARE & REF | | 2 | STREET ADDRESS, CITY, STA 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | TE, ZIP |
| | home's plan to correct this deficien | cy, please contact the nursing home | or the state survey agency. | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIEN MATION) | NCY MUST BE PRECEDED BY | FULL REGULATORY |
| F 0226 | (continued from page 23) been completed. Interview with allegation of abuse had not been had reported on O4/08/13 that the provide not documentation that are of that the allegation had been rewer logged in an abuse investigs revealed no entry regarding Residenthe Administrator was indenthed the investigation. Resident if of the women that. According to Coordinator asked the resident if investigation revealed RN #8 state reported she had told the resident if investigation revealed RN #8 state reported she had told the resident assessed by the facility to be interestigation of abuse was unsulfunction was a stated the incident of the most assessed by the facility to be interested to a nurseles and the incident in the most asted the incident of the most assessed and the incident in the most asted the incident didn't seem like information of the allegation of abuse was unsulfuncted in the incident of the most asted the incident in the most asted the incident didn't seem like information of the allegation facility's investigation had not be 2:00 PM; 6:40 PM; and on 03/29 approximately 5:40 PM, and spol forgotten to inform him of the allegation. Administrator #2 stated attention. Administrator #2 stated attention. Administrator #2 stated attention. Administrator #2 initia 03/27/13 and that he didn't ask (If the arevealed he was an aprogress. In my heart of hearts I have gotten to reportable. Further interview revolved resident stated he/she did not wan provide resident care. Administrator Was should have been sen 03/29/13 at 4:11 PM revealed he resident stated he/she did not wan provide resident care. Administrator was unsured the social Worker/Abuse Coordinator on 04/04/13, the facing agencies until 04/06/13, the facing agencies un | Administrator #2 on 04/09/13 at 3:03 thoroughly investigated and reporter investigation was not complete. At my action had taken to ensure resider ported to the appropriate State Ager ation log at the end of each day. How dent #30. 4. A review of the facility hat Resident #4 had made an allegate interviewed on 03/28/13 and repohe/she had alleged someone was must facility's investigation, the reside the woman was RN #8 and the resident ed Resident #4 did make the statem to use the call light for assistance inviewable were interviewed in regar stantitated based on Resident #4's ruled on the morning of 03/24/13 Resident on the morning of 03/24/13 Resident enterview Rn #8 on 03/24/13 by the Weeker. The DON stated on 03/25/13 she in instrator or interview RN #8. The District or on the experiment of the interview Rn #8 in the solution of the statem of the interview Rn #8 in the solution of the solution | das required until the Social Worth the time of the interview, Administ were protected during the faccies. According to Administrato wever, review of the facility's in 's investigation dated 04/01/13 retion of abuse on 03/24/13, three rited that no one had been mean tean to him/her the resident statectent didn't really mean it. The Soc dent stated, Yeah my little nurse, nent on 03/24/13 that she was me nestead of getting up on her own. rds to their treatment. The investinoderately impaired cognitive abident #4 alleged the RN was mean in or provide care for the resider leth #4 was upset the morning of he floor; and called the Administ with the DON of 04/02/13 at 8:4 and Manager. She stated she did not reviewed Resident #4; got side DON stated on 03/27/13, the Corpa alone of the incident. 3/27/13 to obtain an interview. A heduled 12-hour shift. The DON abuse did not occur. However, the w. Interview with Administrator #2 stated the Die ta an investigation related to the end in the Administrator #2 stated the Die ta an investigation related to the end in the DON agreed I was the proper of the should have been notified of neident. Continued interview with administrator #2 stated the DON agreed I was the proper of the facility for the should have been notified of neident. Continued interview with administrator the should have been notified of neident. Continued interview with administrator the should have been notified of neident. Continued interview with administrator the should have been notified of neident. Continued interview with administrator the should have been notified of neident. Continued interview with administrator the should have been notified of neident. Continued interview with nearly should be not down in a chart to allowing RN #8 to erview, he and the DON agreed I was better than not of the facility's for the facility's congoins reported to the appropriate State Agencies on 04/09/13 at 2:55 PM on the facility is not the facility is not the should have been notified of neident. State Agencies on 04/0 | instrator #2 could ility's investigation or #2, the allegations vestigation log sevealed on 03/27/13, days prior. According to o (her/him). When the 1 he/she had told one cial Worker/Abuse Further review of the ant to the resident. RN #8 All residents igation concluded ility. Interview with RN into the resident and tt. RN #8 stated she 03/24/13. However, RN trator and DON. RN #8 to PM revealed she was or give the Weekend tracked with something sorate Nurse Consultant The DON stated she fter interviewing the stated since RN #8 and he DON acknowledged the or #2 on 03/28/13 at dent on 03/27/13, at ON informed him she had allegation. It was allegation with Administrator on 03/27/13 while the able and stated, In e and ncident and stated the #2 stated RN #8 should the incident; and, h Administrator #2 on work her shift after the RN #8 could continue to now allowing the y's investigation 04/04/13, they overheard a stuck in your arm. ocial Worker/Abuse required state with the Corporate considered the gaudits, the te Agencies late, on treporting the 13 at 11:09 AM, revealed tion involving Resident #31 3:03 PM revealed 4/08/13 with staff and lity staff around igation log revealed her facility provided an on the following: The Administrator #2. The daughter on 04/09/13. A body to obtained from the lab entered the gaudits, the texture of the facility provided an on the following: The Administrator #2. The daughter on 04/09/13. A body to obtained from the lab entered on 04/10/13. An are for Resident #30 on the resident who reside on eallegation of dive on 04/06/13. A body to obtained from the lab entered the gause. The Regional entered the gause of the model on 04/10/13. An are for Resident #30 on the resident |

FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 24 of 59 Event ID: YL1O11 Facility ID: 185337

| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|------------------------------|---|--|--|
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | 04/09/2013 |
| CORRECTION | NUMBER | | |
| NAME OF PROVIDER OF S | 185337 SUPPLIER | STREET ADDR | EESS, CITY, STATE, ZIP |
| LEE COUNTY CARE & R | EHABILITATION CENTER | 246 EAST MAI | |
| For information on the pursi | ng home's plan to correct this deficien | cy, please contact the nursing home or the state sur | |
| (X4) ID PREFIX TAG | <u> </u> | DEFICIENCIES (EACH DEFICIENCY MUST BE | |
| | OR LSC IDENTIFYING INFOR | | |
| F 0226 | staff including Department Direc Contractor by 04/06/13, with con Team on 04/12/13. Staff not sche Independent Contractor was secu oversight and education related to will provide one on one education regarding protection, reporting, a initiated continued abuse education scheduled to work will receive the as needed, or who are on leave of of Nursing, Assistant Director of Regional Staff. On 04/12/13 thirt Dietary Manager, Housekeeping above to determine their feelings voiced. A body audit was comple body audit therefore the audit was Development Coordinator), on Octoproate office, Director of Meensure that no physical signs and injuries. On 04/12/13 Departmen Nurse Assistant (C.N.A.) (State F. (36) residents, to interview for an binder called the AOC binder loc Services Director, Department M Administrator, Director of Nursi Managers, Assistant Director of Manager) or Regional staff (Clin Director, Chief Nurse Executive, daily which were initiated on 04/protected without any evidence owill be reported immediately to the sident care area immediately. Tan investigation, and report to the | f an incident report dated 03/28/13 for bruises. The tors and Regional Staff received education regardin pletion of a posttest. All staff were re-educated by duled, on leave or who work as needed, will be rered on 04/07/13 to remain onsite at the facility dail of abuse, to include investigation, reporting, and promet with administrator 42. Director of Nursing, and I and investigation of allegations of abuse by 04/12/13 on regarding identifying, reporting, and ensuring residence will receive the education upon returning Nursing, Unit Manager, Social Services Director, Yefour (34) interviews were conducted by the Depa Director) for residents with a Brief Interview for M of safety and identify any allegations of mistreatm test for eighty-one (81) residents, there were an addit as not performed on those nine (9), by Administrativ/12/13 and regional nurses (Signature Care Consultical Review -RN from the corporate office) for resymptoms of abuse were present. Results of body: t Managers (Dietary Manager, Staffing Coordinato Registered Nurse Aides) assigned to residents with y noted change of behavior or any signs of fear. Al ated In the Administrator's office. Administrator, # anagers (MDS Coordinators, Dietary Manager, Unical Program Director, Regional Nurse Consultant, Clinical Reimbursement Consultant, Director of Na 13/13 with residents who have a BIMS score of 7 of a buse, neglect, or misappropriation. Findings of she Charge Nurse will notify the Administrator. The Coffice of Inspector General, any allegations of ab S Coordinators, Dietary Manager, Housekeeping D | ng abuse, completed by an Independent the Department Directors and Regional educated upon returning to work. The y until 04/13/13 to provide continued tection. The Independent Contractor he Interim Social Services Director 3. The Independent Contractor his Independent Contractor sident safety on 04/11/13. All staff work during that time frame, who work to work, by Administrator #2, Director Staff Development Coordinator, or urtment Managers (Staffing Coordinator, Internal Status (BIMS) score of seven (7) or ent or abuse. There were no concerns tional nine (9) residents who refused a ve Nurses (MDS Coordinators, DON, Staff Itants, Internal Audit Director -RN from the sidents with a BIMS score below 7 to audits did not reflect any physical r) also met with license nurse and Certified a BIMS of seven (7) or less, thirty-six II above interviews were placed in a 2, Director of Nursing, Interim Social susekeeping Director, Social Service Director, Plant Operations Director, Unit Medical Records Director, Rehabilitation Signature Care Consultant, Internal Audit Indedical Review) conducted 20 interviews or above, to ensure residents feel signs and symptoms of potential abuse he alleged perpetrator, if known, from the e Administrator will immediately initiate use or injuries of unknown origin. |
| F 0226 | resident property. **NOTE- TERMS IN BRACKET Based on interview, record review determined the facility failed to himplemented for six of twenty-ni suspicion of an incident of abuse | istreatment, neglect, or abuse of residents or the TS HAVE BEEN EDITED TO PROTECT CONFIL w, and a review of the facility's policy and procedurave an effective system to ensure policy and proceener residents (Residents #1, #4, #19, #29, #30, and was reported immediately, failed to ensure that at the state of the stat | DENTIALITY** res and investigations, it was dures related to abuse were \$31). The facility failed to ensure a horough investigation was conducted |
| | of abuse and during the investiga On 02/17/13, facility staff witnes approximately 7:35 AM. Staff att Coordinator to report the allegatistaff left a voice message on the the Staff Development Coordinator the Staff Development Coordinatistaff observed the abuse. After reprotected from potential further a Nursing (DON) and/or Social Walleged abuser from direct care gion the floor with residents during talked with the other staff, and at Nurse Consultant on what action after staff observed the abuse. Afte investigation, interviews, and had occurred and the allegation or record review revealed LPN #1 df alsification of documentation. (failed to immediately initiate an iduring an investigation, and faile abuse involving Residents #4, #1 in place to ensure the development was likely to cause, serious injury were identified on 03/01/13 and | a staff member, and failed to ensure reside tion process. Facility staff failed to ensure an allegised Licensed Practical Nurse (LPN) #1, the Charge empted, between 11:30 AM and 12:00 PM, to conton per the facility's policy. The Social Worker/Abus Coordinator's telephone. Stafor/Nurse Manager on 02/17/13, at approximately 1 ceipt of the report of alleged abuse, the facility fail buse. The facility's policies and procedures stated torker were the staff that could make any immediate ving. Interviews revealed LPN #1 continued to be the time the Staff Development Coordinator/Nurse tempted to get direction from the Social Worker/Al to take. LPN #1 remained in direct resident care ut rer completion of the facility's investigation, Admia a review of the witness statements, he could not cof abuse was determined to be unsubstantiated by this don't return to the facility and was terminated from the Te23 and F225.) In addition, interview and nivestigation, failed to ensure residents were proteed to notify the Administrator and appropriate State 9, #29, #30, and #31. (Refer to F225.) The facility's interview and implementation of policies and procedures to the facility and the procedures to the facility and the procedures to the facility and the facility a | ation of abuse was reported timely. e Nurse, verbally abuse Resident #1 at tact the facility's Social Worker/Abuse use Coordinator was unavailable and if reported the allegation of abuse to 1:40 AM, approximately four hours after ed to ensure residents were the Administrator and/or Director of decisions related to the removal of the in charge of resident care and remained e Manager initiated the investigation, buse Coordinator, the DON, and the nitl 12:30 PM, approximately five hours nistrator #1 reported as a result of the properties of the facility on 02/25/13 related to record review revealed the facility ted from further potential abuse Agencies for allegations of potential s failure to have an effective system to protect residents from abuse caused, or eility. Immediate Jeopardy situations |
| | determined to exist on 02/17/13 a notified of the Immediate Jeopar ongoing. The facility provided ar removal of the Immediate Jeopar 04/22-04/23/13, as alleged in the Facility Practices F226 - S/S E, w effectiveness of systemic change policy, dated 01/2012, revealed, a and the Administrator, Director ocharge nurse who receives the rejimmediately reported to the charginvestigation was to be initiated if family, and/or visitors who had p efforts to investigate and address to receive measures to ensure his process. The policy further stated related to the removal of individu 1. A review of the facility's invesput to bed. However, based on dethe resident to bed due to the resisuspended on 02/17/13 pending to | and is ongoing at 42 CFR 483.13 Resident Behavior by on 03/01/13 and 03/29/13 and was informed on acceptable credible Allegation of Compliance (Ad yon 04/17/13. The State Survey Agency (SSA) was acceptable AOC, with remaining noncompliance a while the facility develops and implements a Plan of a sand quality assurance activities. The findings inclusing report or suspicion of an incident was to be report. Further review revealed, any report or suspicions on the properties of t | r and Facility Practices. The facility was 004/09/13 the Immediate Jeopardy was DC) on 04/17/13 with the facility alleging erified removal of the Immediate Jeopardy on t 42 CFR 483.13 Resident Behavior and f Correction and monitors the ude: Review of the facility's abuse orted immediately to the charge nurse, were to be notified immediately by the on of an incident of abuse was to be The policy also revealed a thorough ving staff members, residents, tor/designee would make all reasonable d to them; and that the resident was he incident and during the investigation ker would make any immediate decisions to the total leged or suspected abuse. The total leged or suspected abuse. The total leged or suspected abuse. The total leged of suspected abuse of the total leged of suspected abuse. The total leged of suspected abuse of the total leged of suspected abuse. The total leged of suspected abuse of the total leged of suspected abuse. The total leged of suspected abuse of the total leged of suspected abuse of the total leged of suspected abuse. The total leged of suspected abuse of the total l |

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 25 of 59

PRINTED:3/30/2014 FORM APPROVED

| CT A TEN TEN TE OF | (VI) PROVIDER (GVIDIVIER | AND THE WAY IN CONTRACTOR | | (X3) DATE SURVEY |
|--------------------------------|---|--|--|---|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | N | COMPLETED |
| AND PLAN OF | IDENNTIFICATION | B. WING | | 04/09/2013 |
| CORRECTION | NUMBER | | | |
| NAME OF BROWINGS OF S | 185337 | ern | DEET ADDRESS CITY STA | TE ZID |
| | | | | .IE, ZIP |
| LEE COUNTY CARE & RI | EHABILITATION CENTER | | ATTYVILLE, KY 41311 | |
| For information on the nursing | ig home's plan to correct this deficien | cy, please contact the nursing home or | r the state survey agency. | |
| (X4) ID PREFIX TAG | | DEFICIENCIES (EACH DEFICIENC | Y MUST BE PRECEDED BY | FULL REGULATORY |
| | | MATION) | | |
| For information on the nursing | g home's plan to correct this deficien SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR. (continued from page 25) facility. According to the investig the course of the investigation, at by the facility and attempts to co- terminated from employment by Development Coordinator/Unit N facility on [DATE] at approxima and #2 came to her and stated they fe Resident #1. The Staff Developm put to bed and the LPN refused to Worker/Abuse Coordinator prior Manager stated after the houseke individuals on the unit, and had ti Aides and an Activities Worker a stated LPN #1 remained on the n stated she did not remove LPN # her to pull the LPN from the floo Coordinator, for further guidance the Staff Development Coordinat and informed LPN #1 that she we she could remove staff from the further interview revealed she w facility's policy revealed any repa the Administrator, Director of Nt charge nurse who receives the re- her immediate safety and wellbeir record review revealed these prov 02/28/13 at 4:53 PM confirmed so Development Coordinator/Nurse investigation. Further interview varianed to report allegations of ab stated she was not sure if a nurse abuse had been made and staff co abuse training provided by the fa revealed LPN #1 did not have a fa revealed he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator prior interview, he was not aware the fa worker/Abuse Coordinator state following an allegation of suspec social Worker/Abuse Co | cy, please contact the nursing home or DEFICIENCIES (EACH DEFICIENC MATION) ration, dated 02/22/13, the facility did tempts were made to contact LPN #1 fract the LPN were unsuccessful. A rethe facility on 02/25/13 for falsification fanager on 02/28/13 at 5:35 PM and at tely 11:00 AM to do a weekend check. It a little uneasy and uncomfortable with the coordinator/Unit Manager stated to notifying her in accordance with facepers spoke with her she went out on the staff fill out written statements. She and had them fill out writtens statement ursing unit at the nurses' station during the from the floor immediately becauses a few the facility policy; however, she for/Unit Manager, she then contacted the sbeing sent home pending the final in floor, and the allegation had to be justifus as not sure what was being reported by that on surging and Abuse Coordinator, as approort. In addition, the policy stated the ring following the incident and during the edures were not implemented. Interview he had received a voice mail message with the Social Worker/Abuse Coordinuse to her, the DON or the Administra could remove a staff member from direct and during the station of the staff to seek guit to the removal of the alleged perpetrate acility's abuse policy did not instruct staff to seek guit to the removal of the alleged perpetrate acility's abuse policy did not instruct staff to seek guit to the removal of the alleged perpetrate acility's abuse policy did not instruct staff to seek guit to the removal of the alleged perpetrate acility's abuse policy did not instruct staff to seek guit to the removal of the alleged perpetrate acility's abuse policy instructed staff to seek guit to the removal of the alleged perpetrate acility's abuse policy instructed staff to seek guit to the removal of the alleged perpetrate acility and the state appropriate the facility's abuse policies policy, which included reporting, inverse not aware the policy indicated only indicated only indicated only the facility's abuse policies policy, which i | r the state survey agency. Y MUST BE PRECEDED BY MUST BE PRECEDED BY not substantiate that the abuse for interview. However, LPN iview of LPN #1's employee find of documentation. Interview gain on 03/04/13 at 11:07 AM. At approximately 11:30 AM. At approximately 12:30 AM. At approximatel | coccurred. During #I was no longer employed le revealed the LPN was with the Staff I revealed she came to the -11:40 AM, Housekeepers #I etween LPN #I and r Resident #I asked to be contact the Social pment Coordinator/Unit on, talked to egistered Nurse ordinator/Unit Manager estigation. She it was appropriate for I Worker/Abuse phone. According to for further direction, I she did not know if from the floor. However, review of the charge nurse, and mediately by the res to ensure his or ever, interview and buse Coordinator further an allegation of revealed staff had been to Coordinator further an allegation of revealed the last 2/28/13 at 5:20 PM, was loud by nature. of the investigation, 33/05/13 at 4:25 PM the Social the Social the Social was made. Per e alleged mistrator and/or DON n direct care giving or Operations, Chief ey had been developed N and/or Social Worker direct contact evealed the resident the resident two to three e/she reported the Coordinator on 04/05/13, investigations d. The Social the resident two to three e/she reported the Coordinator on 04/05/13, investigations d. The Social the resident two to three e/she reported the Coordinator on 04/05/13, investigations d. The Social the resident two to three e/she reported the Coordinator on 04/05/13, investigations d. The Social the resident stated the resident stated the resident stated the resident stated the social the |
| | in the shower and had wrapped a not completed and the allegation incident was reported). It could n from further potential abuse whil to provide resident care at the fac contact SRNA #13 to inform the completed. An interview conduct Social Worker/Abuse Coordinate that occurred on 03/22/13. Accor been completed. Interview with 4 allegation of abuse had not been had reported on 04/08/13 that the | 0.03/22/13, from 8:00 PM to 9:00 PM, sheet too tight around the resident's ne was not reported to the appropriate sta ot be determined by a review of docune the investigation was being conducte lility. According to the initial report, da SRNA that she would be suspended at ed with the facility's Social Worker/Al or had informed Administrator #2 on 04 ding to the Social Worker/Abuse Coord dministrator #2 on 04/09/13 at 3:03 P thoroughly investigated and reported a investigation was not complete. At the vaction had taken to ensure residents | eck. Continued review reveale ate agencies until 04/09/13, (simentation if the facility had pred, or if the facility allowed Stated 04/09/13, the facility had nd not allowed to work until thouse Coordinator on 04/09/13 44/08/13, of the abuse allegation dinator the investigation of the PM revealed Administrator #2 as required until the Social Wo te time of the interview, Adminentation of the interview of the | d the investigation was xteen days after the otected residents RNA #13 to continue attempted to to einvestigation had been at 11:09 AM, revealed the ninvolving Resident #30 e allegation had not was not aware the reker/Abuse Coordinator nistrator #2 could |
| | | y action had taken to ensure residents ported to the appropriate State Agencies | | |
| FORM CMS-2567(02-99) | Event ID: YL1011 | Facility ID: 185337 | If contin | nuation sheet |

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

PRINTED:3/30/2014 FORM APPROVED OMB NO 0938-0391

| CENTERS FOR MEDICARE C | C WIEDICAID SERVICES | | | OMB NO. 0938-0391 |
|--------------------------------|---|--|--|--|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCTIO | ON | (X3) DATE SURVEY COMPLETED |
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | | 04/09/2013 |
| CORRECTION | NUMBER | | | 34/05/2015 |
| | 185337 | lan | | and and |
| NAME OF PROVIDER OF SUI | | | FREET ADDRESS, CITY, STA | TE, ZIP |
| LEE COUNTY CARE & REH | IABILITATION CENTER | | 46 EAST MAIN STREET EATTYVILLE, KY 41311 | |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home | or the state survey agency. | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | | CY MUST BE PRECEDED BY | FULL REGULATORY |
| | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR (continued from page 26) were logged in an abuse investig; revealed no entry regarding Resist the Administrator was informed the investigation, Resident #4 was facility questioned the resident if of the women that. According to Coordinator asked the resident if investigation revealed RN #8 star reported she had told the resident assessed by the facility to be inte the allegation of abuse was unsul #8 on 03/28/13 at 8:07 PM revea Resident #4 did not want RN #8 documented the incident in the ni #8 stated she should have told an stated the incident didn't seem lik informed of the allegation agains Manager any further instructions else; and did not notify the Admi questioned her related to a nurse' called RN #8 and had her come i nurse, the DON and Administrat Resident #4 denied the allegation facility's investigation had not be 2:00 PM; 6:40 PM; and on 03/29 approximately 5:40 PM, and 590 forgotten to inform him of the all Further, Administrator #2 stated attention. Administrator #2 stated attention and just forgotten to do any have reported the incident to ano that RN #8 should have been sen 03/29/13 at 4:11 PM revealed he resident stated he/she did not war provide resident care. Administr RN to continue to work during the revealed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 Even though the investigation recontinue to work during the revealed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 Even though the investigation reconding the social Worker/Abuse Coordinator on 04/04/13, the faciagencies until 04/ | DEFICIENCIES (EACH DEFICIEN | ever, review of the facility's invision of abuse on 03/24/13, three of the dath of the facility's invision of abuse on 03/24/13, three of the dath of the facility's invision of abuse on 03/24/13, three of the dath of the facility's invision of abuse on 03/24/13, three of the dath of the facility in the facility of the facility of the facility of the facility in the facility of the facility in th | estigation log vealed on 03/27/13, days prior. According to 0 (her/him). When the he/she had told one ial Worker/Abuse Further review of the in to the resident. RN #8 All residents gation concluded litty. Interview with RN in to the resident and t. RN #8 stated she 03/24/13. However, RN rator and DON. RN #8 5 PM revealed she was to give the Weekend tracked with something orate Nurse Consultant The DON stated she file interviewing the stated since RN #8 and the DON acknowledged the fire interviewing the stated since RN #8 and the DON acknowledged the file interviewing the stated since RN #8 and the don 03/27/13, at DN informed him she had fillegation. The was half paying the do work on view with Administrator on 03/27/13 while the ble and stated, In the and tracked RN #8 should the incident; and, Administrator #2 on work her shift after the the RN #8 could continue to thow allowing the ye's investigation 04/04/13, they overheard a stuck in your arm. cial Worker/Abuse equired state with the Corporate considered the g audits, |
| | | duled, on leave or who work as need red on 04/07/13 to remain onsite at t | | |

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet Page 27 of 59

PRINTED:3/30/2014

| CENTERS FOR MEDICAR | E & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF S LEE COUNTY CARE & R | | 246 E. | ET ADDRESS, CITY, STA AST MAIN STREET TYVILLE, KY 41311 | TE, ZIP |
| For information on the nursin (X4) ID PREFIX TAG | - | cy, please contact the nursing home or the DEFICIENCIES (EACH DEFICIENCY) | ne state survey agency. | / FULL REGULATORY |
| F 0226 | (continued from page 27) oversight and education related to will provide one on one education regarding protection, reporting, a initiated continued abuse educatis scheduled to work will receive th as needed, or who are on leave of of Nursing, Assistant Director of Regional Staff. On 04/12/13 thirt Dietary Manager, Housekeeping above to determine their feelings voiced. A body audit was comple body audit therefore the audit wa Development Coordinator), on 04 Corporate office, Director of Meensure that no physical signs and injuries. On 04/12/13 Departmen Nurse Assistant (C.N.A.) (State F (36) residents, to interview for an binder called the AOC binder loc Services Director, Department M Administrator, Director of Nursir Managers, Assistant Director of Manager) or Regional staff (Clin Director, Chief Nurse Executive, daily which were initiated on 04/ protected without any evidence o will be reported immediately to the resident care area immediately. Tan investigation, and report to the | o abuse, to include investigation, reportin n with Administrator #2, Director of Nur di investigation of allegations of abuse to regarding identifying, reporting, and e is re-education by 04/12/13. Staff not sci absence will receive the education upon Nursing, Unit Manager, Social Services y-four (34) interviews were conducted b Director) for residents with a Brief Inter of safety and identify any allegations of the for eighty-one (81) residents, there we not performed on those nine (9), by Ad 4/12/13 and regional nurses (Signature C lical Review -RN from the corporate off symptoms of abuse were present. Result the Managers (Dietary Manager, Staffing C degistered Nurse Aides) assigned to resic y noted change of behavior or any signs ated In the Administrator's office. Adminanagers (MDS Coordinators, Dietary Manager, Staffing C dursing, Admissions Director, Activities ical Program Director, Regional Nurse C Clinical Reimbursement Consultant, Din 13/13 with residents who have a BIMS s f abuse, neglect, or misappropriation. Fir ine Charge Nurse will notify the Administ Office of Inspector General, any allegat S Coordinators, Dietary Manager, House fice Manager, Staffing Coordinators, Dietary Manager, House will notify the Administ Office of Inspector General, any allegat S Coordinators, Dietary Manager, House fice Manager, Staffing Coordinator, Plar | sing, and the Interim Social by 04/12/13. The Independe ensuring resident safety on 0 heduled to work during that 1 returning to work, by Adm Director, Staff Developmen y the Department Managers view for Mental Status (BI mistreatment or abuse. The ere an additional nine (9) reliministrative Nurses (MDS are Consultants, Internal Alice) for residents with a BINs of body audits did not refoordinator) also met with 1 lents with a BIMS of seven of fear. All above interview nitration #2, Director of Numanager, Housekeeping Director, Medical Records fonsultant, Signature Care Corector of Medical Review) of the consultant signature Care Corector of Signs and sympton remove the alleged perpetr strator. The Administrator witons of abuse or injuries of skeeping Director, Social Sekeeping Director, Socia | Services Director ant Contractor A/4/11/13. All staff time frame, who work inistrator #2, Director at Coordinator, or to (Staffing Coordinator, MS) score of seven (7) or re were no concerns sidents who refused a Coordinators, DON, Staff dit Director -RN from the MS score below 7 to lect any physical icense nurse and Certified (7) or less, thirty-six ws were placed in a rsing, Interim Social stor, Social Service Director, so Director, Unit Director, Rehabilitation Consultant, Internal Audit conducted 20 interviews e residents feel ms of potential abuse ator, if known, from the vill immediately initiate unknown origin. rrvice Director, Administrator, |
| | Based on interview, record review determined the facility failed to h implemented for six of twenty-ni suspicion of an incident of abuse in of abuse in of abuse and during the investiga On 02/17/13, facility staff witnes approximately 7:35 AM. Staff att Coordinator to report the allegatistaff left a voice message on the stress of the staff Development Coordinat staff observed the abuse. After reprotected from potential further a Nursing (DON) and/or Social Woalleged abuser from direct care gion the floor with residents during talked with the other staff, and att Nurse Consultant on what action after staff observed the abuse. Afte investigation, interviews, and had occurred and the allegation or record review revealed LPN #1 of falsification of documentation. (Failed to immediately initiate an induring an investigation, and faile abuse involving Residents #4, #1 in place to ensure the development was likely to cause, serious injury were identified on 03/01/13 and determined to exist on 02/17/13 a notified of the Immediate Jeopart ongoing. The facility provided and the Immediate Jeopart ongoing. The facility provided and the Administrator, Director ocharge nurse who receives the rejimmediately reported to the charginvestigation was to be initiated in family, and/or visitors who had pefforts to investigate and address to receive measures to ensure his process. The policy further stated related to the removal of individu 1. A review of the facility's investigation to bed. However, based on de the resident to bed due to the resisuspended on 02/17/13 pending tinterviewed, and one resident reprocessing to the facility sinvestigation, and one resident reprocessing to the investigation to the limental pending to the time suspended on 02/17/13 pending tinterviewed, and one resident reprocessing the resident to bed the to the resignity. | RS HAVE BEEN EDITED TO PROTECT w, and a review of the facility's policy an ave an effective system to ensure policy en residents (Residents #1, #4, #19, #29, was reported immediately, failed to ensure volving a staff member, and failed to ensure volving a staff member, and failed to ensure of the process. Facility staff failed to ensure declicensed Practical Nurse (LPN) #1, empted, between 11:30 AM and 12:00 Property of the facility's policy. The Social Worker/Abuse Coordinator's telep or/Nurse Manager on 02/17/13, at approceipt of the report of alleged abuse, the fouse. The facility's policies and procedusorker were the staff that could make any ving. Interviews revealed LPN #1 continues that the staff Development Coordinate that the staff Development Coordinate are view of the facility and was term (steep of the witness statements, he can also approper of the staff policies and procedusor of a staff that could make any ving. Interviews revealed LPN #1 continues that the staff Development Coordinate are view of the witness statements, he can also approper of the facility's makes terminated to be unsubstant did not return to the facility and was terminated for the vitness statements, he can also approper of the vitness statements, he can also approper of the vitness and proper of the vitness and the vitness of the vitness statements, and the one of the vitness of | d procedures and investigat and procedures related to a #30, and #31). The facility are that a thorough investigat sure residents were protected an allegation of abuse was the Charge Nurse, verbally 'M, to contact the facility's 'Orker/Abuse Coordinator whome. Staff reported the alle with the contact the facility's in the contact the facility's in the contact the facility's in the contact the facility failed to ensure residents stated the Administrator immediate decisions related used to be in charge of residuator/Nurse Manager initiate Worker/Abuse Coordinator ent care until 12:30 PM, apinon, Administrator #1 report ould not come to a firm contact the facility. However, and the facility in th | buse were failed to ensure a tition was conducted ed following a report s reported timely, abuse Resident #1 at Social Worker/Abuse as unavailable and agation of abuse to timately four hours after lents were and/or Director of to the removal of the lent care and remained ed the investigation, , the DON, and the proximately five hours ted as a result of clusion that abuse ver, interview and 12/25/13 related to vealed the facility potential abuse grations of potential un effective system s from abuse caused, or Jeopardy situations d Quality of Care was ctices. The facility was necitate Jeopardy was with the facility alleging f the Immediate Jeopardy on Resident Behavior and monitors the ne facility's abuse y to the charge nurse, ad immediately by the of abuse was to be revealed a thorough rrs, residents, did make all reasonable at the resident was uring the investigation any immediate decisions suspected abuse. , and wanted to be ould not allow staff to put was immediately ther residents were er resident at the coccurred. During |
| | by the facility and attempts to conterminated from employment by | ntact the LPN were unsuccessful. A review the facility on 02/25/13 for falsification of flanager on 02/28/13 at 5:35 PM and aga | ew of LPN #1's employee fi of documentation. Interview | le revealed the LPN was with the Staff |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 28 of 59 DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:3/30/2014

| CENTERS FOR MEDICARE & | MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|---|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 105557 | | | |
| NAME OF PROVIDER OF SUPPLIER | | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & REHA | ABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION

F 0226

(continued... from page 28) facility on [DATE] at approximately 11:00 AM to do a weekend check. At approximately 11:30 AM-11:40 AM, Housekeepers #1

#2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and #2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be put to bed and the LPN refused to allow staff to put the resident to bed and that they had attempted to contact the Social Worker/Abuse Coordinator prior to notifying her in accordance with facility policy. The Staff Development Coordinator/Unit Manager stated after the housekeepers spoke with her she went out on the floor, started an investigation, talked to individuals on the unit, and had the staff fill out written statements. She stated she spoke with State Registered Nurse Aides and an Activities Worker and had them fill out witness statements. The Staff Development Coordinator/Unit Manager stated LPN #1 remained on the nursing unit at the nurses' station during the time she initiated the investigation. She stated she did not remove LPN #1 from the floor immediately because she was trying to determine if it was appropriate for her to pull the LPN from the floor. Between 11:30 AM and 12:30 PM she attempted to call the Social Worker/Abuse Coordinator, for further guidance, per the facility policy; however, she was unable to contact her via phone. According to the Staff Development Coordinator/Unit Manager, she then contacted the Facility's Nurse Consultant for further direction, and informed LPN #1 that she was being sent home pending the final investigation. She further stated she did not know if she could remove staff from the floor, and the allegation had to be justifiable to remove facility staff from the floor. Further interview revealed she was not sure what was being reported by the housekeepers was abuse. However, review of the facility's policy revealed any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the ch Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be investigation. Further interview with the Social worker/Abuse Coordinator on 03/04/13, at 1:23 PM, revealed staff had be trained to report allegations of abuse to her, the DON or the Administrator. The Social Worker/Abuse Coordinator further stated she was not sure if a nurse could remove a staff member from direct resident care in the event an allegation of abuse had been made and staff could not reach Administrative staff. Review of staff training records revealed the last abuse training provided by the facility was in December 2012. Interview with Administrator #1 on 02/28/13 at 5:20 PM, revealed LPN #1 did not have a history of abuse and staff may have misinterpreted the LPN since she was loud by nature. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation, and the facility was not able to substantiate that abuse occurred. Interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social Worker/Abuse Coordinator prior to the removal of the alleged perpetrator after an allegation of abuse was made. Per interview, he was not aware the facility's abuse policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, review of the facility's policy revealed only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct to the alleged. direct contact related to the alleged or suspected abuse. Interview with the facility's Vice President of Operations, Chief Nurse Executive, and the Nurse Consultant on 03/04/13 at 5:05 PM, revealed the facility's abuse policy had been developed at the corporate level and they were not aware the policy indicated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact following an allegation of suspected abuse. 2. Interview with Resident #29 on 04/05/13 at 5:50 PM, revealed the resident reported he/she was afraid of SRNA #14 because he had touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the incident to the facility's Social Worker/Abuse Coordinator. Interview with the Social Worker/Abuse Coordinator on 04/05/13, at 3:30 PM, revealed she also acted as the facility's Abuse Coordinator, was responsible to assist with investigations related to abuse/neglect, and to provide staff education/in-service related to abuse/neglect as indicated. The Social Worker/Abuse Coordinator stated in accordance with facility policy allegations of alleged abuse were to be immediately investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator further stated she had on 06/20/11, as well as when the policy, which included reporting, investigation, and resident protection of abuse allegations, was revised in March 2013. Further interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she and Administrator #1 talked with the resident about the incident and the resident stated he/she felt the touching incident was inappropriate. The Social Worker/Abuse Coordinator further stated Resident #29 told her he/she did not feel the incident was abuse. According to the Social Worker/Abuse Coordinator, SRNA #14 was moved to another unit in the facility following the report by Resident #29 and was allowed to continue to provide direct care for residents. Although the Social Worker/Abuse Coordinator stated she did obtain statements from Resident #29, the resident's daughter, SRNA #14, and a staff nurse assigned to the Seasons Unit, she did not further investigate the alleged incident. The Social Worker/Abuse Coordinator also stated since the resident stated she did not feel the incident was abuse, she did not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the Social Worker/Abuse Coordinator revealed she was no longer employed by the facility effective 04/08/13 due to illness. During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or Administrator; and they would direct her on the procedures to follow when an allegation of abuse was reported, including investigation, protection, and reporting. The Social Worker/Abuse Coordinator stated she had missed doing some things during the investigation of the incident reported by Resident #29. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was currently acting as the facility's Administrator, and was not aware of the incident involving Resident #29. Further interview with the Vice President of Operations on 04/05/13 at 7:30 PM, revealed SRNA #14 continued to work at the facility in the provision of direct care after Resident #29 had reported the incident and was still providing direct resident care on 04/05/13. However, the Vice President of Operations stated SRNA #14 was suspended from employment after he was informed of the alleged incident on 04/05/13. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and be could provide no suspended from emproyment after he was informed of the aneged incident on 04/03/15. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and he could provide no evidence the allegation had been reported to the state agencies as directed by the facility's abuse policy. 3. Review of the facility's investigation, initiated by the facility's Social Worker/Abuse Coordinator on 03/24/13, revealed Resident #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while in the shower and had wrapped a sheet too tight around the resident's neck. Continued review revealed the investigation was not completed and the allegation was not reported to the appropriate state agencies until 04/09/13, (sixteen days after the incident was reported). It could not be determined by a review of documentation if the facility had protected residents from further potential abuse while the investigation was being conducted, or if the facility allowed SRNA #13 to continue to provide resident care at the facility. According to the initial report, dated 04/09/13, the facility had attempted to contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator thad informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was not aware the allegation of abuse had not been thoroughly investigated and reported as required until the Social Worker/Abuse Coordinator had reported on 04/08/13 that the investigation was not complete. At the time of the interview, Administrator #2 could provide no documentation that any action had taken to ensure residents were protected during the facility's investigation or that the allegation had been reported to the appropriate State Agencies. According to Administrator #2, the allegations were logged in an abuse investigation log at the end of each day. However, review of the facility's inve facility questioned the resident if he/she had alleged someone was mean to him/her the resident stated he/she had told one

Facility ID: 185337

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

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|
| AND PLAN OF | IDENNTIFICATION | B. WING | 04/09/2013 | |
| CORRECTION | NUMBER | | | |
| NAME OF PROVIDER OF SUF | 185337 PPLIER | STREET ADDRESS, CITY | , STATE, ZIP | |
| LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | | | | |
| | | y, please contact the nursing home or the state survey agency | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE IATION) | ED BY FULL REGULATORY | |
| F 0226 | Coordinator asked the resident if investigation revealed RN #8 state reported she had told the resident assessed by the facility to be inter the allegation of abuse was unsub #8 on 03/28/13 at 8:07 PM reveal Resident #4 did not want RN #8 to documented the incident in the nu stated the incident didn't seem lik informed of the allegation against Manager any further instructions. else; and did not notify the Admir questioned her related to a nurse's called RN #8 and had her come in nurse, the DON and Administrator Resident #4 denied the allegation facility's investigation had not bee 2:00 PM; 6:40 PM; and on 03/29/approximately 5:40 PM, and spok forgotten to inform him of the all Further, Administrator #2 stated I attention. Administrator #2 initial 30/327/13 and that he didn't ask (D #2 revealed he was aware RN #8 investigation was in progress. Interportable. Further interview reve DON had just forgotten to do any have reported the incident to anot that RN #8 should have been sent 03/29/13 at 4:11 PM revealed he resident stated he/she did not wan provide resident care. Administra RN to continue to work during the revealed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 Even though the investigation reversed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 Even though the investigation reversed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 Even though the investigation reversed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 Even though the investigation reversed SRNA #1 and SRNA #8 Lab Technician tell Resident #19 was completed to the appropriate State #10 Administrator #2 could not recall to add the social Worker/Abuse Coordin but she could not recall the date on Administrator #2 could not recall for the allegation was determined to be a 04/06/13. The Corporate Nurse E allegation, 6. An interview conduct the Social Worker/Abuse Coordin but she could not recall the date on the sum of | the facility's investigation, the resident didn't really mean it. The woman was RN #8 and the resident stated, Yeah my little id Resident #4 did make the statement on 03/24/13 that she we to use the call light for assistance instead of getting up on her viewable were interviewed in regards to their treatment. The is one one into the resident's room again or provide care for the rise's notes, and only thought Resident #4 alleged the RN was o come into the resident's room again or provide care for the rise's notes, and only thought Resident #4 was upset the mornitor nurse; removed herself from the floor; and called the Ade an allegation of abuse. Interview with the DON on 04/02/13 RN #8 on 03/24/13 by the Weekend Manager. She stated she The DON stated on 03/25/13 she interviewed Resident #4; go istrator or interview RN #8. The DON stated on 03/27/13, to obtain an interview face and the resident for the resident for interview and resident for the work early on the evening of 03/27/13 to obtain an interview £2 allowed RN #8 to work her scheduled 12-hour shift. The she and Administrator #2 decided abuse did not occur. Howe in finished at the time of the interview. Interview with Admin 13 at 10:25 AM and 4:11 PM revealed he became aware of the yest and the proper of the prope | nurse. Further review of the as mean to the residents. RN #8 own. All residents own. All residents nvestigation concluded ve ability. Interview with RN is mean to the resident and esident. RN #8 stated she ng of 03/24/13. However, RN ministrator and DON. RN #8 at 8:45 PM revealed she was did not give the Weekend it side tracked with something to Corporate Nurse Consultant dent. The DON stated she ew. After interviewing the DON stated since RN #8 and ver, the DON acknowledged the istrator #2 on 03/28/13 at e incident on 03/27/13, at the DON informed him she had of the allegation. In the properties of | |

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 Previous Versions Obsolete

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0226 (continued... from page 50) as needed, or who are on leave of absence will receive the education upon returning to work, by Administrator #2, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Staff Development Coordinator, or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or above to determine their feelings of safety and identify any allegations of mistreatment or abuse. There were no concerns voiced. A body audit was complete for eighty-one (81) residents, there were an additional nine (9) residents who refused a body audit therefore the audit was not performed on those nine (9), by Administrative Nurses (MDS Coordinators, DON, Staff Development Coordinator), on 04/12/13 and regional nurses (Signature Care Consultants, Internal Audit Director -RN from the Corporate office, Director of Medical Review -RN from the corporate office) for residents with a BIMS score below 7 to ensure that no physical signs and symptoms of abuse were present. Results of body audits did not reflect any physical injuries. On 04/12/13 Department Managers (Dietary Manager, Staffing Coordinator) also met with license nurse and Certified Nurse Assistant (C.N.A.) (State Registered Nurse Aides) assigned to residents with a BIMS of seven (7) or less, thirty-six (36) residents, to interview for any noted change of behavior or any signs of fear. All above interviews were placed in a binder called the AOC binder located In the Administrator's office. Administrator #2, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) F 0281 Make sure services provided by the nursing facility meet professional standards of quality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to ensure services provided met professional standards of quality for eight of twenty-nine sampled residents. On 03/28/13 at 4:00 PM, the facility failed to obtain blood glucose levels (Accuchecks) as ordered by the physicians for Residents #2, #6, #10, #21, and #22. The facility failed to consistently document transactions from the emergency drug kits by failing to complete usage reports for Residents #3 and #9. Additionally, Resident #5 had physician's orders [REDACTED]. The findings include: 1. As a result of observation, interview, and record review, it was determined that staff failed to follow accepted standards of practice by failing to follow facility policy regarding the use of emergency medication kits (i.e., E-Boxes). It was determined that staff did not always document transactions of its E-Boxes by failing to complete and turn in usage reports to both their provider pharmacy and to the facility's Medical Records Department. Because of this practice, the facility was unable to monitor the use of its E-Boxes or account for medications removed from the boxes. Review of the facility's policy related to the use of E-Boxes (Policy #3.4, Emergency Pharmacy Service and Emergency Kits) revealed: A) Item #8 of the policy stated that upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on the emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency nurse documents the medication or item used on the emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. B) Item #9 stated that use of emergency medications were to be noted on the resident's current MAR. On 03/28/13 at approximately 2:00 PM, while reviewing the Medication Administration Records (MARs) for residents living on the Seasons Unit, Resident #9 was noted to have received a 10-day regimen of the antibiotic [MEDICATION NAME], 100 milligrams (mg) (one capsule twice daily) for a urinary tract infection. The drug was scheduled for administration at 9:00 AM and 9:00 PM, and the MAR revealed the resident's therapy began on 03/16/13 at 9:00 AM and concluded on 03/25/13 at 9:00 AM, and that all 20 ordered doses were given as ordered. Review of the resident's orders revealed the [MEDICATION NAME] order was posted on 03/15/13, and dispensing records revealed that 20 capsules were delivered from the pharmacy on 03/16/13. The time of delivery would have been at approximately 11:00 PM. Thus, the resident's initial two doses were obtained from a source other than the actual prescription. At 3:00 PM on 03/28/13, the Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of [MEDICATION NAME] 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy had concluded on 03/25/13, the container revealed the presence of 12 capsules, leading one to conclude the resident may have failed to receive up to 12 of Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of [MEDICATION NAME] 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy had concluded on 03/25/13, the container revealed the presence of 12 capsules, leading one to conclude the resident may have concluded on 03/25/13, the container revealed the presence of 12 capsules, leading one to conclude the resident may have oncluded on 03/25/13, the container revealed the presence of 12 capsules, leading one to conclude the resident may have oncluded on 03/25/13. The aide was shown the resident may have and acknowledged that reviewed concerning Resident #9's extra antibiotics. The aide was whown the resident's medication drawer and acknowledged that resident's drawer still contained [MEDICATION NAME] capsules even though the therapy had been completed since 03/25/13. The aide was shown the resident's MAR and she also acknowledged that all 20 ordered doses had been documented as given. Although KMA #3 was unable to explain why the 12 capsules remained in the drawer, the aide commented that it was very common to initiate a new medication order through use of the facility's E-Boxes. The aide also explained that when a new medication is ordered late in the workday (e.g., after 6:00 PM), the medication may not arrive from the provider pharmacy for approximately 24 hours. In cases such as that, the therapy may be started by using medications from the E-Box or, in some situations, by ordering a 24-hour supply from their backup or secondary pharmacy. During the course of the interview, the unit's E-Box was inspected, showing that it was authorized to contain 4 capsules of [MEDICATION NAME] to work the capsules of [MEDICATION NAME] to work the provider pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to receipt by the pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records D The resident's clinical record revealed the order was given by the physician on 03/14/13, and review of the pharmacy's shipping manifest revealed the order was signed upon receipt on 03/14/13. Thus, at least the first three doses would have

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 31 of 59

PRINTED:3/30/2014 FORM APPROVED

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | ON | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED |
|---|---|---|--|--|
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER 185337 | B. WING | | 04/09/2013 |
| NAME OF PROVIDER OF SU | JPPLIER | | TREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & RE | HABILITATION CENTER | | 46 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| | 1 | cy, please contact the nursing home | | WELL BEGIN TRODA |
| (X4) ID PREFIX TAG | OR LSC IDENTIFYING INFOR | | ICY MUST BE PRECEDED BY | Y FULL REGULATORY |
| | summary splan to correct this deficient SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR (continued from page 31) been obtained from a source other evealed the prescription box stil dispensed on 03/14/13, and still dispensed on 03/14/13, and still dispensed on 03/14/13, and still dispensed on the resident could about Resident #3's [MEDICATI the E-Box. Since the pharmacy order that staff had to obtain the resident continued to remain a mystery. To fithe [MEDICATION NAME] 1 04/05/13. Moreover, records at the NAME]. 3. Review of a facility 1 the resident's [DIAGNOSES REI care plan were as follows: explai #5 on 04/01/13 at 4:00 PM reveal Observations on 04/01/13 at 4:30 Observations on 04/01/13 at 4:30 Observation on 04/01/13 at 4:31 liters per minute, and put the nascontinued to receive the oxygen: Resident #5 continued to receive at 5:10 PM revealed, The doctor 04/02/13 at 8:15 AM revealed Observation at 9:50 AM revealed observation and 19:50 AM revealed observation at 9:50 AM revealed observation and 19:50 AM reveal | Bucy, please contact the nursing home DEFICIENCIES (EACH DEFICIEN | cor the state survey agency. Wer, inspection of the resident's it was labeled as having contained the state of the state survey agency. Wer, inspection of the resident's it was labeled as having contained the duration of therapy concluded ordered doses. On 03/28/13, Kh eresident's five extra [MEDICA and of the day on 03/14/13, it was, so the source of the remaining unable to obtain evidence that st is also verified by the facility's hed Resident #3 did not receive of Dl. Review of the medical recorders [REDACTED]. Review of the medical recorders [REDACTED]. Review of the medical recorders [REDACTED]. Review of the physician. Approas a Physician orders [REDACTED] as designated smoke room with not at #5 was not wearing oxygen who his/her room, turned the oxygerved on 04/01/13 at 5:15 PM to nula. Observation at 6:00 PM on ansal cannula. Interview with Ref if needed to. Continued observed on at 5 liters per minute via ansaer on at 3.5 liters per minute via ansaer on at 3.5 liters per minute, obtained to a substain his/her blood pressure. Fac. At the time the resident return; however, Resident #5 did not 1:30 PM revealed Resident #5 have not 02 liters per minute, obtaine be 97 percent. Resident #5 did not 1:30 PM revealed Resident #5 have not 02 liters per minute, obtaine be 97 percent. Resident #5 have not 04/02/13 at 12:20 PM revealed #5 was supposed to have oxyge en setting was too high, the SR to sex supposed to have oxyge en setting was too high, the SR to sex of daily living. A review of Resident #2's oxygen administration sett as ordered by the physician. On oved the resident's oxygen administration sett as ordered by the physician of the p | medication drawer 1 30 capsules, was 1 on 03/23/13. Thus, it 1/4 #3 was interviewed to 1/4 was |
| | | continuity of resident care, such as uired, or what nursing tasks needed | | |
| TODA C. C. C. A. C. | F TD - NT - 1011 | 77 W YD 4050 | | |

PRINTED:3/30/2014

| CENTERS FOR MEDICA | RE & MEDICAID SERVICES | | FORM APPROVED OMB NO. 0938-0391 |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF | 185337 SUPPLIER | STREET ADI | DRESS, CITY, STATE, ZIP |
| | REHABILITATION CENTER | 246 EAST M | IAIN STREET |
| For information on the nurs | sing hame's plan to correct this deficien | BEATTYVII cy, please contact the nursing home or the state: | LLE, KY 41311 |
| (X4) ID PREFIX TAG | • | DEFICIENCIES (EACH DEFICIENCY MUST) | |
| | OR LSC IDENTIFYING INFOR | | |
| F 0281 | (continued from page 32) | | |
| F 0281 | quality. **NOTE- Based on observation, interview, ensure services provided met pro 4:00 PM, the facility failed to ob #10, #21, and #22. The facility fa complete usage reports for Residi include: 1. As a result of observal accepted standards of practice by E-Boxes). It was determined that in usage reports to both their providerice, the facility was unable to Review of the facility's policy rel revealed: A) Item #8 of the policy rurse documents the medication of faxed to the pharmacy with the or kit until it is scheduled for exchain resident's current MAR. On 03/25 for residents living on the Season [MEDICATION NAME], 100 m administration at 9:00 AM and 9: concluded on 03/25/13 at 9:00 Al revealed the [MEDICATION NAME], 100 m administration at 9:00 AM revealed the [MEDICATION NAME] on resident's initial two doses were consident's initial two doses were completed since 03/25/13. The aid been documented as given. Althocommented that was very commencial that when a new medic from the provider pharmacy for a medications from the E-Box or, in During the course of the interview [MEDICATION NAME] 100 mg a dual copy usage report, with the second (yellow) copy to be place. Department. Although the box considered that the Acting DON had provider pharmacy for a medication from the E-Box for Resident #9. On 04 Director estimated that stafff usate the considerity in the course of the antibiotic [MEDICATIO | s Unit, Resident #9 was noted to have received a lligrams (mg) (one capsule twice daily) for a uri 00 PM, and the MAR revealed the resident's the M, and that all 20 ordered doses were given as o ME] order was posted on 03/15/13, and dispens of ME] order was posted on 03/15/13, and dispens of ME] order was posted on 03/15/13, and dispens audited and revealed that Resident #9's drawer yon 03/15/13 for 20 capsules, and although the f 12 capsules, leading one to conclude the reside on 03/28/13, Kentucky Medication Aide (KMA concerning Resident #9's extra antibiotics. The ident's drawer still contained [MEDICATION N de was shown the resident's MAR and she also a ugh KMA #3 was unable to explain why the 12 non to initiate a new medication order through u ation is ordered late in the workday (e.g., after 6 proroximately 24 hours. In cases such as that, the n some situations, by ordering a 24-hour supply w, the unit's E-Box was inspected, showing that i. The aide explained that when removing a meditop (white) copy being placed inside the E-Box 1 in a receipt box (located near the E-Box) to be intained some yellow copies from previous trans d for Resident #9. On 04/03/13 at approximately EDON (Director of Nursing), and the CNE (Chivided pharmacy records related to Resident #9's oof (e.g., usage reports) that any doses of [MED /03/13 at 2:40 PM, during an interview with the lly failed to fill out and forward usage reports in stances any usage reports that were placed insi poses. He further explained that a daily per dien is removed from the E-Boxes. The Director explicated the second of the place of | FIDENTIALITY** It was determined the facility failed to y-nine sampled residents. On 03/28/13 at ed by the physicians for Residents #2, #6, the emergency drug kits by failing to onysician's orders [REDACTED]. The findings mined that staff failed to follow see of emergency medication kits (i.e., as the search of this medications removed from the boxes. The supply item from the emergency kit, the yof this information should be immediately dications were to be noted on the the Medications were to be noted on the the Medication Administration Records (MARs) as 10-day regimen of the antibiotic inary tract infection. The drug was scheduled for early began on 03/16/13 at 9:00 AM and ordered. Review of the resident's orders sing records revealed that 20 capsules were at approximately 11:00 PM. Thus, the contained the package of [MEDICATION NAME] e therapy had concluded on 03/25/13, the contained the package of [MEDICATION NAME] e therapy had concluded on 03/25/13, the contained the package of [MEDICATION NAME] e therapy had concluded on 03/25/13, the contained the package of [MEDICATION NAME] e therapy had concluded on 03/25/13, the contained the package of [MEDICATION NAME] e therapy have failed to receive up to 12 of A) #3 who was currently passing medications on aide was shown the resident's medication NAME] capsules even though the therapy had been acknowledged that all 20 ordered doses had capsules remained in the drawer, the aide see of the facility's E-Boxes. The aide also 6:00 PM), the medication may not arrive the therapy may be started by using from their backup or secondary pharmacy. It was authorized to contain 4 capsules of lication from the E-Box, staff was expected to fill out 6 forwarded to the Medical Records sactions there were no copies found related to 10 t |
| | | ed the resident leaving the facility's designated s PM and 5:00 PM revealed Resident #5 was not | |

Observations on 04/01/13 at 4:30 PM and 5:00 PM revealed Resident #5 was not wearing oxygen while in the hallway. Observation on 04/01/13 at 5:10 PM revealed Resident #5 returned to his/her room, turned the oxygen on at a setting of 4.5 liters per minute, and put the nasal cannula on. Resident #5 was observed on 04/01/13 at 5:15 PM to be in his/her room and continued to receive the oxygen at 4.5 liters per minute via nasal cannula. Observation at 6:00 PM on 04/01/13 revealed Resident #5 continued to receive oxygen at 4.5 liters per minute via nasal cannula. Interview with Resident #5 on 04/01/13 at 5:10 PM revealed, The doctor told me I could turn up the oxygen if I needed to. Continued observation of Resident #5 on 04/02/13 at 8:15 AM revealed the resident lying in bed with oxygen on at 5 liters per minute via nasal cannula. Observation

Facility ID: 185337

DDINTED:3/30/2014

| CENTERS FOR MEDICARE | | | | FORM APPROVED |
|--------------------------------|--|--|---|---|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCT | ΓΙΟΝ | OMB NO. 0938-0391 (X3) DATE SURVEY |
| DEFICIENCIES | / CLÍA | À. BUILDING | | COMPLETED |
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | B. WING | | 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SU | | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & REF | HABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing hor | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFORI | | ENCY MUST BE PRECEDED B' | Y FULL REGULATORY |
| F 0281 | (continued from page 33) on 04/02/13 at 9:30 AM revealed Observation on 04/02/13 at 9:35 Observation at 9:50 AM revealed minute via nasal cannula. Observ 3.5 liters per minute. Additional 6 without his/her oxygen in use and the resident's blood pressure and the oxygen concentrator was obse on and was not receiving the oxyper minute; however, at that time pulse oxygenation, and noted the trouble breathing during the obse revealed Resident #5's oxygen with permitted to adjust the resident's stated the nurses were supposed to axygen level was too high for an independent and rarely needed an via nasal cannula and, according and the nurse would change the olevel a few weeks ago, and she in PM revealed on 04/02/13 at 12:1: minute and RN #5 adjusted the orequest of the surveyor, RN #5 sta #5, and was not aware Resident #12/20/12, with [DIAGNOSES RI completed on 12/28/12 revealed the facility ass assistance for locomotion and lim Comprehensive Care Plan dated (was to obtain Accuchecks as ord of Resident #22 on 03/28/13 at 6. Aide, stating, Honey, I'm so thirs some insulin. Review of Resident resident's 4:00 PM Accucheck as REDACTED]. A review of Resident resident to have no cognitive imp Resident #2's Comprehensive Care the facility was to obtain Accuche Review of Resident #6's TAR on as ordered by the physician. 6. TI Resident #2's Comprehensive Care the facility was to obtain Accuche Review of Resident #6's TAR on as ordered by the physician. Intervie related to not receiving the Accucheck was resident #2's TAR on 03/28/13, a ordered by the physician. Intervie related to not receiving the Accuchered by the physician for The sident #10's Comprehensive Care the facility was to obtain Accuchered by the physician for The sident #10's Comprehensive Care the facility was to obtain Accuchered by the physician for the sident #10's Comprehensive Careled Note of Resident #10's Comprehensive | Resident #5 was in bed with oxy AM revealed Resident #5 was in a Resident #5 was in a Resident #5 returned to his/her ration on 04/02/13 at 10:30 AM re observations at 11:30 AM and 11: 1, at 11:35 AM, requested staff to the resident returned to his/her rocred to be set at 5 liters per minu gen. Observation on 04/02/13 at 1 RN #5 adjusted the resident's oxy results of the pulse oxygenation trations for 04/01/13 at 1 knough 04/das supposed to be on 2 liters per noxygen, and if she thought the oxy omenitor each resident's oxygen esident. Interview with SRNA #1: sything. SRNA #13 stated Resident ox SRNA #13, if the resident's oxy xygen level if needed. According formed the resident's nurse. Interview of 5 PM, SRNA #11; sported Reside xygen setting to 2 liters per minute ent to Resident #5's roomand obset the oxygen setting to 2 liters per minute ent to Resident #5's roomand obset the oxygen setting to 2 liters per minute ent to Resident #5's roomand obset the oxygen setting to 2 liters per minute ent to Resident #5's roomand obset the oxygen setting to 2 liters per minute ent to Resident #5's roomand obset the oxygen setting to 2 liters per minute ent to Resident #6's roomand obset the oxygen setting to 2 liters per minute ent to Resident #6's roomand obset the oxygen setting to 2 liters per minute ent to Resident #6's accepted by the resident was treed by the physician. Review of 104 by the physician. Review of 104 by the physician. Since levels as ordered by the physician. O3/28/13, at 6:15 PM revealed the resident was try; they always check my sugar be levels as ordered by the physician. O3/28/13, at 6:15 PM revealed the resident was try they always check my sugar be levels as ordered by the physician. The lent #6's Quarterly MDS assessment in the facility was to obtompleted on 12/26/12, revealed the resident #2 or Plan dated 02/16/13, revealed the facility admitted Resident #2 or 03/02/13; revealed the facility admitted Resident #2 or 03/02/14 tor replan dated 03/04 by the physician. In the facility admitted R | igen on at 3.5 liters per minute via a wheelchair in the hallway and di oom and was observed to receive evealed Resident #5 was in bed an 35 AM on 04/02/13 revealed Resident his/her blood pressure. Fac om. At the time the resident return tet; however, Resident #5 did not 12:30 PM revealed Resident #5 haygen to 2 liters per minute, obtaine to be 97 percent. Resident #5 did not 12:30 PM revealed Resident #5 did not 12:30 PM revealed Resident #5 did not 20:13. Interview with SRNA #11. minute via nasal cannula. The SRN ygen needed adjusting she inform use. SRNA #11 stated, It could be 3 on 04/02/13 at 12:20 PM reveale mt #5 was supposed to have oxyger ygen setting was too high, the SR1 to SRNA #13, Resident #5 had tview with Registered Nurse (RN) ent #5's oxygen administration settle as ordered by the physician. On served the resident's oxygen admited to 2 liters per minute and stated to son Resident #5's nursing unit, with at times. 4. The facility admitted in #22's Admission Minimum Data tive summary score of 12, to requisites of daily living. A review of Ras at risk for hyper/[DIAGNOSES Resident #22's physician's orders [complaining of a dry mouth to a Nefore supper but they didn't do it.] Record (TAR) revealed the facility admitted Resident #6 on 1 ent completed on 01/02/13 revealed the in the demobility, transfers, and am the resident was at risk for hyper/[IReview of Resident #6's physician's orders [Rimiled to obtain the resident's 4:00 F at 3:16 PM revealed the resident #21 thensive Care Plan dated 02/16/12 than Accuchecks as ordered by the the facility admitted Resident #21 thensive Care Plan dated 02/16/12 than Accuchecks as ordered by the the facility assessed the resident was at risk for hyper/[IReview of Resident #21's TAR on 03/22 then six Care Plan dated 02/16/12 than Accuchecks as ordered by the the facility assessed the resident of the Accucheck not being on the 10 on 03/29/13 at 3:13 PM revealed the facility assessed the resident was at six for hyper and the resident for physician in the resident | d not have oxygen on. oxygen at 5 liters per d was receiving oxygen at dent #5 was in the hallway ility staff obtained ed to his/her room, have the nasal cannula d oxygen in use at 5 liters d the resident's ot appear to be having on 04/02/13 at 12:15 PM A stated she was not ed the nurse. The SRNA a problem, if the dd Resident #5 was very on on at 2 liters per minute NA notified the nurse, rned up his/her oxygen #5 on 04/02/13 at 12:30 ing was on 5 liters per 04/02/13 at 12:30 PM at iistration level to be at he physician's as unfamiliar with Resident Resident #22 on Set (MDS) assessment re extensive esident #22's REDACTED], and the facility REDACTED], Observation Medication Administration think I may need y had failed to obtain the 2/28/11, with [DIAGNOSES d the facility assessed the bulation. A review of DIAGNOSES REDACTED], and 's orders [REDACTED], and 's orders [REDACTED], and y MDS assessment nent and to require EDACTED]. A review of DIAGNOSES REDACTED], and My MDS assessment nent and to require EDACTED]. Review of MA Accucheck as enied any problems on 04/17/12, with , revealed the resident was at risk physician. A review of Resident o have a cognitive es of daily living. 3/13, at 6:15 PM revealed the n Resident #21 on btained as ordered on IOSES REDACTED]. A review of review of Resident to have a valving. A review of Resident #21 on btained as ordered on IOSES REDACTED]. A review of resident to have a valving. A review of Resident #21 on btained as ordered on IOSES REDACTED]. A review of resident to have a valving. A review of Resident #21 on btained as ordered on IOSES REDACTED]. A review of resident to have a valving. A review of resident denied Staff Development 4:00 PM (exact time care. The SDC stated on with the prior Seasons Unit. Interview or cover the floor, but |
| F 0282 | Based on observation, interview, ensure services were provided in Resident #19's care plan directed bedside. However, observations of position and that there was a fall (dated December 2010) revealed | IS HAVE BEEN EDITED TO PR record review, and review of faci accordance with the care plan for staff to utilize the bed in the lowe on 04/01/13 and 04/12/13 revealed mat on the floor. The findings ince the care plan would be implemen | written plan of care. ROTECT CONFIDENTIALITY** lity policy it was determined the foone of twenty-nine sampled resid est position and a fall mat on the flucture of the facility's Cated through the integration of asset to 8/04/44 with IDFAGNOSES R | acility failed to ents (Resident #19). oor at the 9's bed was in the low re Plan policy ssment findings. A review |

of the medical record revealed the facility admitted Resident #19 on 08/04/04 with [DĬAGNOSES REDACTED]. Further review of the medical record revealed the facility assessed the resident to be at risk for falls related to history of falls and fractures. A review of the comprehensive care plan dated 01/19/13 revealed facility staff was to utilize a low bed for Resident #19 with a fall mat beside the bed. In addition, a review of the Nurse Aide Care Plan (guide for direct care staff) also revealed the resident's bed was to be in a low position and a fall mat was to be placed on the floor beside the bed. Observations at 2:50 PM, 4:02 PM, and 5:30 PM on 04/01/13, and at 8:25 AM, 9:35 AM, 11:25 AM, and 12:45 PM on 04/02/13 revealed Resident #19's bed was at the normal height, and there was no mat on the floor beside the bed. Interview with State Registered Nurse Aide (SRNA) #9 at 9:30 AM on 04/03/13 revealed she knew the low bed and mat on the floor were listed in the additional notes on the SRNA care plan, but stated a nurse had told her the use of the low bed and mat on the floor had been discontinued, therefore she had not placed the mat on the floor or the bed in the lowest position. An interview

Facility ID: 185337

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

If continuation sheet Page 34 of 59

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCT A. BUILDING | ΓΙΟΝ | (X3) DATE SURVEY COMPLETED |
|---|--|--|---|---|
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | B. WING | | 04/09/2013 |
| NAME OF PROVIDER OF SUI | 185337 PPLIER | | STREET ADDRESS, CITY, STA | L ATE, ZIP |
| LEE COUNTY CARE & REHABILITATION CENTER | | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| For information on the nursing l (X4) ID PREFIX TAG | rsing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0282 | (continued from page 34) was conducted with Registered Nurse (RN) #5 at 9:35 AM on 04/03/13. The RN stated the low bed and the use of the mat on the floor had been discontinued. However, after reviewing the medical record the RN acknowledged the order was current and had not been discontinued. | | | |
| F 0282 | Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure services were provided in accordance with the care plan for one of twenty-nine sampled residents (Resident #19). Resident #19's care plan directed staff to utilize the bed in the lowest position and a fall mat on the floor at the bedside. However, observations on 04/01/13 and 04/12/13 revealed staff failed to ensure Resident #19's bed was in the low position and that there was a fall mat on the floor. The findings include: A review of the facility's Care Plan policy (dated December 2010) revealed the care plan would be implemented through the integration of assessment findings. A review of the medical record revealed the facility admitted Resident #19 on 08/04/04 with [DIAGNOSES REDACTED]. Further review of the medical record revealed the facility admitted Resident to be at risk for falls related to history of falls and fractures. A review of the comprehensive care plan dated 01/19/13 revealed facility staff was to utilize a low bed for Resident #19 with a fall mat beside the bed. In addition, a review of the Nurse Aide Care Plan (guide for direct care staff) also revealed the resident's bed was to be in a low position and a fall mat was to be placed on the floor beside the bed. Observations at 2:50 PM, 4:02 PM, and 5:30 PM on 04/01/13, and at 8:25 AM, 9:35 AM, 11:25 AM, and 12:45 PM on 04/02/13 revealed Resident #19's bed was at the normal height, and there was no mat on the floor beside the bed. Interview with State Registered Nurse Aide (SRNA) #9 at 9:30 AM on 04/03/13 revealed she knew the low bed and mat on the floor had been discontinued, therefore she had not placed the mat on the floor or the bed in the lowest position. An interview was conducted with Registered Nurse (RN) #5 at 9:35 AM on 04/03/13. The RN stated the low be | | | |
| F 0332 | Keep the rate of medication erro **NOTE- TERMS IN BRACKET Based on observation, interview. | 'S HAVE BEEN EDITED TO PR | | was free from |
| | medication error rates of five percent or greater, Medication pass observations conducted on 03/28/13, 03/29/13, 04/01/13, and 04/02/13 resulted in the assessment of three medication errors (Residents #1 and #5 and unsampled Resident D) out of fifty-two opportunities, for a medication error rate of 5.76 percent. The findings include: 1. Resident D received nourishment and oral medications via a feeding tube. During the morning medication pass on 04/02/13 at 9:30 AM, the resident was observed to have six oral dosage forms which included four tablet dosage forms (Aspirin 81 milligrams (mg), [MEDICATION NAME] 10 mg, [MEDICATION NAME] 150 mg, and a Multivitamin with Minerals). During the preparatio medications, Licensed Practical Nurse (LPN) #4 was observed to crush the four tablets and mix the resultant powders in a dose cup. During the administration procedure, the nurse checked the placement of the resident's tube, checked the tube's residual, and then performed an initial flush of the tube with approximately 30 milliliters (ml) of water. The nurse then separately administered two liquid dosage forms (the liquid contents of two fish oil capsules and 2.5 ml of [MEDICATION NAME] Acid Syrup), both of which had been diluted with a small portion of water. The nurse then administered the mixture of the crushed tablets mixed with a small amount of water (approximately 30 ml) followed by a liberal post-flush with more water. Before leaving the room, the nurse concluded the care by administering a bolus feeding consisting of a can of [MEDICATION NAME] 1.2. Following the medication pass observation, review of Resident D's clinical record revealed no evidence of a physician's orders [REDACTED]. A review of the facility's policy related to administration of medications via feeding tube (Policy 7.10, titled Enteral Tubes, dated 12/12) was conducted. Item #10 of the policy stated, Medication administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems | | | 8, 03/29/13, 04/01/13, ed Resident D) out of D received 3 at 9:30 AM, the n 81 milligrams (mg), ss). During the preparation of the esultant powders in a c, checked the tube's er. The nurse then ml of [MEDICATION dministered the mixture of post-flush with more ting of a can of nical record revealed no tion of medications via ated, Medication re known re and after giving the term care facilities and provide individual 1 associations do note oted standard of imes, American Journal 02/13 at 5:00 PM, LPN #4 ministering via a dent D that morning pass that the s, unless otherwise |
| | 2. Observations of Medication Aide #7 administering medication on 03/28/13, at 1:36 PM revealed staff obtained Resident #5's Proair HFA inhaler from the medication cart and handed it to the resident for self-administration. However, the Medication Aide failed to provide Resident #5 with any instruction, direction, or reminders for accurately self-administering the medication. Resident #5 placed the inhaler to his mouth and quickly inhaled two puffs without any time elapsing between inhalations. Review of a large red manufacturer's warning label on the box the Medication Aide removed the Proair HFA inhaler from, prior to giving it to Resident #5, revealed waiting one minute between inhalations was required. Review of Resident #5's Comprehensive Care Plan dated 03/20/13, revealed the resident was unsafe to self-administer medication and would be administered medications by staff. An interview with Medication Aide #7 on 03/28/13, at 2:40 PM, revealed she did not provide a reminder to Resident #7 to wait between inhalation because he is pretty competent, I guess he was in a hurry, he does what he wants to. 3. Observations of Medication Aide #3 administering Resident #1's routine scheduled 5:00 PM medication on 03/28/13, at 4:50 PM revealed the resident had been scheduled to receive [MEDICATION NAME] 100 mg at 3:00 PM, but had not been administered the medication as ordered. Medication Aide #3 stated in an interview on 03/28/13, at 5:00 PM that she must have overlooked the medication and failed to administer the [MEDICATION NAME] at the scheduled time. The observations of the medication pass were reported to Administrator #2, the Acting Director of Nursing, and the Chief Nurse Executive on 04/04/13 at 10:00 AM. The Acting Director of Nursing acknowledged she was aware of the standard of practice regarding the need to administer tube medications separately, and to flush between the medications administered through the tube. | | | |
| F 0332 | Based on observation, interview, medication error rates of five per and 04/02/13 resulted in the asses fifty-two opportunities, for a med nourishment and oral medications resident was observed to have six [MEDICATION NAME] 10 mg, medications, Licensed Practical Nose cup. During the administratiresidual, and then performed an inseparately administered two liquid NAME] Acid Syrup), both of whith the crushed tablets mixed with a swater. Before leaving the room, the MEDICATION NAME] 1.2. Fol evidence of a physician's orders [| S HAVE BEEN EDITED TO PR and record review, it was determined to read the record review, it was determined to read the record record of the reducation pass of sment of three medication errors ication error rate of 5.76 percent. It is via a feeding tube. During the moral dosage forms which include [MEDICATION NAME] 150 mg lurse (LPN) #4 was observed to comprocedure, the nurse checked to read the reducation of the reducation of the reducation of the tube with approximation and the reducation of the reducation of the reducation pass observed to the reducation pass observed pass observed the reducation pass observed the r | rong time) to less than 5%. ROTECT CONFIDENTIALITY** ned the facility failed to ensure it beservations conducted on 03/28/12 (Residents #1 and #5 and unsampl The findings include: 1. Resident orning medication pass on 04/02/1d four tablet dosage forms (Aspirig, and a Multivitamin with Mineral rush the four tablets and mix the rush the placement of the resident's tubeximately 30 milliliters (ml) of wate to of two fish oil capsules and 2.5 portion of water. The nurse then a tately 30 ml) followed by a liberal planinistering a bolus feeding consist vation, review of Resident D's clircility's policy related to administration of the miles of the policy stonducted. Item #10 of the policy stonducted. Item #10 of the policy stonducted. | 3, 03/29/13, 04/01/13, ed Resident D) out of D received 3 at 9:30 AM, the n 81 milligrams (mg), s). During the preparation of the esultant powders in a c, checked the tube's er. The nurse then mil of [MEDICATION] dministered the mixture of boost-flush with more ting of a can of nical record revealed no tition of medications via |

Facility ID: 185337

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCT | ION | (X3) DATE SURVEY COMPLETED |
|----------------------------------|--|---|--|--|
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | A. BUILDING B. WING | | 04/09/2013 |
| CORRECTION | 185337 | | | |
| NAME OF PROVIDER OF SUI | PPLIER | | STREET ADDRESS, CITY, STA | TE, ZIP |
| LEE COUNTY CARE & REH | ABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| For information on the nursing l | nome's plan to correct this deficience | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM | | NCY MUST BE PRECEDED BY | FULL REGULATORY |
| F 0332 | (continued from page 35) administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems between the medications to be mixed together. A minimum of one flush before and after giving the medications is acceptable unless there is a physician's orders [REDACTED]. However, recently long-term care facilities and State Survey Agencies were both reminded of the need to administer all medications separately and to provide individual water flushes between each medication given through a feeding tube. In addition, several professional associations do note that the need to administer all medications separately and to flush between all medications is an accepted standard of practice; notable associations included the Institute for Safe Medication Practices (ISMP), Nursing Times, American Journal of Health-System Pharmacy, Texas Department of Aging and Disability Services, and others. On 04/02/13 at 5:00 PM, LPN #4 was interviewed concerning the issue over the need to administer all medications separately when administering via a feeding tube. The nurse acknowledged she had administered the medications via feeding tube to Resident D that morning according to facility policy, but noted that she had been told by other staff following the medication pass that the current acceptable standard was now to administer the medications separately with in-between flushes, unless otherwise directed by the physician. | | | |
| | #5's Proair HFA inhaler from the Medication Aide failed to provide self-administering the medication time elapsing between inhalations removed the Proair HFA inhaler required. Review of Resident #5's self-administer medication and w 03/28/13, at 2:40 PM, revealed sh pretty competent, I guess he was Resident #1's routine scheduled 5 receive [MEDICATION NAME] stated in an interview on 03/28/12 [MEDICATION NAME] at the self-acting Director of Nursing, and the self-acting the self-acting difference of Nursing, and the self-acting Director of Nursing acting Director of Nursing D | de #7 administering medication on medication cart and handed it to the Resident #5 with any instruction. Resident #5 placed the inhaler to s. Review of a large red manufacture. The recomplete of the recomplete | he resident for self-administration, direction, or reminders for accur- bits mouth and quickly inhaled tv urer's warning label on the box the #5, revealed waiting one minute 03/20/13, revealed the resident wa- by staff. An interview with Medi- esident #7 to wait between inhalat to. 3. Observations of Medication to 4:50 PM revealed the resident h- teen administered the medication verlooked the medication and fail of the medication pass were report 4/13 at 10:00 AM. The Acting Di | . However, the ately you puffs without any Medication Aide between inhalations was as unsafe to cation Aide #7 on ion because he is Aide #3 administering ad been scheduled to as ordered. Medication Aide #3 ed to administrator #2, the rector of Nursing |
| F 0333 | residents were free of significant 4:00 PM, the facility failed to adn facility policy, Medication Admin administered only as ordered by a administer medication, regardless A review of Resident #9's Quarte the resident to have a cognitive st daily living. A review of Residen Diabetes, and the resident was to orders dated March 2013 revealed evening at 4:00 PM. Review of R been administered the insulin as citting up on the bed. Resident #1 Interview with the Staff Develop sometime after 4:00 PM (exact tindirect patient care. The SDC state no communication with the prior on the Seasons Unit. Interview will unit was removed from direct pat assigned to cover the floor but Ac | | OTECT CONFIDENTIALITY** it was determined the facility fail- y-nine sampled residents (Reside dered insulin. The findings incluc ons, dated December 2010, reveal he medication sheet and/or nurse; ed Resident #9 on 11/30/12, with essment completed on 03/04/13 re supervision/limited assistance for ated 03/04/13, revealed a problem the physician. Review of Residen th #9 30 units of [MEDICATION) ation Record (TAR) at 6:15 PM re 19 on 03/29/13 at 3:12 PM, reveale e insulin not being administered a M on 03/28/13, revealed she was s Unit, related to the assigned nurs to being assigned to care for the aware that Accuchecks had not b at 8:00 PM confirmed the nurse as use was made. Administrator #2 st sisions to ensure the continuity of r | nt #9). On 03/28/13 at the and a second process of the ed medications were to be a notes any failure to [DIAGNOSES REDACTED]. Evel be the facility assessed and activities of of uncontrolled and #9's physician's NAMEJ 70/30 insulin every evealed the resident had not ed the resident to be as ordered on [DATE]. Total by Administration to be being removed from residents and had been obtained for residents signed to the Seasons atted the SDC was sesident care, such as |
| F 0333 | residents were free of significant 4:00 PM, the facility failed to adracility policy, Medication Admin administered only as ordered by a administer medication, regardless A review of Resident #9's Quarte the resident to have a cognitive st daily living. A review of Residen Diabetes, and the resident was to orders dated March 2013 revealed evening at 4:00 PM. Review of R been administered the insulin as citting up on the bed. Resident #1 Interview with the Staff Develop sometime after 4:00 PM (exact tindirect patient care. The SDC state no communication with the prior on the Seasons Unit. Interview will unit was removed from direct pat assigned to cover the floor but Ac | | OTECT CONFIDENTIALITY** it was determined the facility fail- y-nine sampled residents (Reside dered insulin. The findings incluc ons, dated December 2010, reveal he medication sheet and/or nurse; ed Resident #9 on 11/30/12, with essment completed on 03/04/13 re supervision/limited assistance for ated 03/04/13, revealed a problem the physician. Review of Residen th #9 30 units of [MEDICATION) ation Record (TAR) at 6:15 PM re 19 on 03/29/13 at 3:12 PM, reveale e insulin not being administered a M on 03/28/13, revealed she was s Unit, related to the assigned nurs to being assigned to care for the aware that Accuchecks had not b at 8:00 PM confirmed the nurse as use was made. Administrator #2 st sisions to ensure the continuity of r | ed to ensure at #9). On 03/28/13 at le: A review of the ed medications were to be s notes any failure to [DIAGNOSES REDACTED]. evealed the facility assessed all activities of of uncontrolled at #9's physician's NAME] 70/30 insulin every evealed the resident had not ed the resident to be es ordered on [DATE]. told by Administration the being removed from residents and had een obtained for residents signed to the Seasons ated the SDC was estident care, such as |
| F 0371 | Store, cook, and serve food in a | safe and clean way. | | |
| | ingredient storage bins were obsethe storage bins were free from colabeled. The findings include: The two ingredient storage bins were the ingredients to possible contain container) and was not labeled with bin was unlabeled. An interview | ew, it was determined the facility frved not to close tightly and as a rontamination. In addition, one of the sanitation tour in the kitchen was observed to be damaged and, as a nination. One of the storage bins reth the name of the contents. The oew was conducted with the Dietard not fit properly, were not airtightion. | esult, the facility could not ensure the storage bins, reported to contait s conducted at 9:20 AM on 04/04, result, the lids would not complet eportedly contained loose flour (o wher storage bin contained a varie y Manager (DM) at 9:30 AM on 0 | the contents of n for n to n n to n n 10 ur, was not n 13. During the tour, ely close which exposed ut of the original ty of pasta; however, 4/04/13. The DM confirmed |

Facility ID: 185337

PRINTED:3/30/2014

| CENTERS FOR MEDICARE & | MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SUP | PLIER | STI | REET ADDRESS, CITY, STA | TE, ZIP |
| LEE COUNTY CARE & REH | ABILITATION CENTER | F:- | 6 EAST MAIN STREET EATTYVILLE, KY 41311 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION

continued... from page 36) F 0371

F 0425

F 0371 Store, cook, and serve food in a safe and clean way.

> Based on observation and interview, it was determined the facility failed to store food under sanitary conditions. Two ingredient storage bins were observed not to close tightly and as a result, the facility could not ensure the contents of the storage bins were free from contamination. In addition, one of the storage bins, reported to contain flour, was not labeled. The findings include: The sanitation tour in the kitchen was conducted at 9:20 AM on 04/04/13. During the tour, two ingredient storage bins were observed to be damaged and, as a result, the lids would not completely close which exposed the ingredients to possible contamination. One of the storage bins reportedly contained loose flour (out of the original container) and was not labeled with the name of the contents. The other storage bin contained a variety of pasta; however, the bin was unlabeled. An interview was conducted with the Dietary Manager (DM) at 9:30 AM on 04/04/13. The DM confirmed the lids on the two storage bins did not fit properly, were not airtight, and as a result, the contents of the bins could be exposed to possible contamination.

Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview and record review, it was determined that the facility failed to ensure the accurate acquiring, receiving, and administering of all drugs and biologicals to meet the needs of two of twenty-nine sampled residents (Residents #3 and #9) and one unsampled resident (Resident D). The facility failed to follow accepted standards of practice regarding the administration of medications via enteral feeding tubes which placed residents with feeding tubes of practice regarding the administration of medications via enteral feeding tubes which placed residents with reeding tubes for receiving nourishment and oral medications at risk of experiency feeding tubes (Resident D). In addition, the facility failed to follow its policy related to use of the facility's Emergency Medication Kit, and failed to monitor and account for all medications removed from the kit (Residents #3 and #9). The findings include: 1. Resident D received nourishment and oral medications via a feeding tube. During the morning medication pass on 04/02/13 at 9:30 AM, the resident was to receive six oral dosage forms which included four tablet dosage forms (Aspirin 81 mg, Namenda 10 mg, Zantac 150 mg, and a Multivitamin with Minerals). During the preparation of the medications, LPN #4 was observed to crush the four tablets, and then mix the resultant powders in a dose cup. During the administration procedure, the nurse checked the placement of the resident's tube, checked the tube's residual, and then performed an initial flush of the tube with approximately 30 milliliters (ml) of water. The nurse then separately administered two liquid dosage forms (the liquid contents of two fish oil capsules and 2.5 ml of Valproic Acid Syrup), both diluted with a small portion of water. The nurse then administered the mixture of the crushed tablets mixed with a small amount of water (approximately 30 ml) followed by a liberal post-flush with more water. Before leaving the room, the nurse concluded the care by administering a bolus feeding consisting of a can of Jevity 1.2. Following the medication pass observation, review of Resident D's clinical record revealed no evidence of a physician's orders [REDACTED]. A review of the facility's policy related to administration of medications via feeding tube (Policy #7.10, titled Enteral Tubes, dated December 2012) revealed Item #10 of the policy stated, Medication administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems between the medications to be mixed together. A minimum of one flush before and after giving the medications was acceptable unless there is a physician's orders [REDACTED]. However, medications should be administered separately with a flush between medications. Interview on 04/02/13 at 5:00 PM, with LPN #4 revealed she administered the medications via feeding tube to Resident D that morning in accordance with facility policy, but noted administered the medications via feeding tube to Resident D that morning in accordance with facility policy, but noted having been told by other staff following the morning medication pass that the current acceptable standard was now to administer the medications separately using flushes between all medications unless otherwise directed by the physician. 2. On 03/28/13 at approximately 2:00 PM, while reviewing the Medication Administration Records (MARs) for residents living on the Seasons Unit, Resident #9 was noted to have received a 10-day regimen of the antibiotic Macrobid 100 mg (one capsule twice daily) for a urinary tract infection. The drug was scheduled for administration at 9:00 AM and 9:00 PM, and the MAR (Medication Administration Record) revealed the resident's therapy began on 03/16/13 at 9:00 AM and concluded on 03/25/13 at 9:00 AM, and that all 20 ordered doses were given as ordered. Review of the resident's orders revealed the Macrobid order was posted on 03/15/13, and dispensing records revealed that 20 capsules were delivered from the pharmacy on 03/16/13. The time of delivery would have been at approximately 11:00 PM, indicating the resident's initial two doses were obtained from a source other than the actual prescription. At 3:00 PM on 03/28/13, the Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of Macrobid 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy concluded on 03/25/13, the container revealed the presence of 12 capsules, indicating the resident may have failed to receive up to 12 of the 20 ordered doses. Interview at 6:30 PM on 03/15/15 for 20 capsules, and although the therapy concluded on 03/25/15, the container revealed the presence of 12 capsules, indicating the resident may have failed to receive up to 12 of the 20 ordered doses. Interview at 6:30 PM on 03/28/13, with KMA #3 concerning Resident #9's extra antibiotics revealed KMA #3 was unable to explain why the 12 capsules remained in the drawer, and stated it was very common to initiate a new medication order through use of the facility's E-Box or in some cases by ordering a 24-hour supply from their backup pharmacy (Rite-Aid). During the course of the interview, the unit's E-Box was inspected, showing that it was authorized to contain 4 capsules of Macrobid 100 mg. The aide explained that when removing a medication from the E-Box staff was expected to fill out a dual copy usage report, with the top (white) copy being placed inside the current E-Box for receipt by the pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records Department. Although the box contained some vellaw copies from previous transactions, there were no copies found related to any Mearshid obtained for placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records Department. Although the box contained some yellow copies from previous transactions, there were no copies found related to any Macrobid obtained for Resident #9. On 04/03/13 at approximately 10:00 AM, the issue of the E-Boxes was discussed with Administrator #2, the Acting Director of Nursing (DON), and the CNE (Chief Nurse Executive). They reported they were unable to locate any proof (e.g., usage reports) that any doses of Macrobid had ever been obtained from the E-Box for Resident #9. On 04/03/13 at 2:40 PM, during an interview with the Director of the provider pharmacy, the Director estimated that staff usually failed to fill out and forward usage reports in the E-Box about 50 percent of the time. He also stated that in most instances any usage reports placed inside the E-Box would be discarded since they were not used for billing purposes. He further explained that a daily per diem the pharmacy received from the facility would cover payment of most items taken from the E-Boxes. The Director explained he was unaware of any complaints regarding residents not being given their medications as ordered. The Director explained it would be impossible to determine why Resident #9 continued to have the 12 capsules of Macrobid in her drawer. However, he did speculate that, because most of their unit-dose pills were packed in strips of 30 pills, it was possible a pharmacy tech could have placed because most of their unit-dose pills were packed in strips of 30 pills, it was possible a pharmacy tech could have placed a full strip of 30 pills in Resident #9's box instead of the ordered 20 capsules. Since the resident's first two doses of a full strip of 30 pills in Resident #9's box instead of the ordered 20 capsules. Since the resident's first two doses of the Macrobid could have likely come from the E-Box, he commented that could explain the presence of the 12 capsules. As a result of an on-site visit to the facility's backup pharmacy on 04/04/13, it was determined that Resident #9 had no prescription activity over the previous 90 days and the 12 extra doses of Macrobid could not be traced to a prescription at the backup pharmacy. 3. During the review on 03/28/13 of the MARs for the residents living on the Seasons Unit, Resident #3 was noted to have been treated with a 10-day course of the antibiotic, Clindamycin 150 mg (one capsule 3 times daily for 10 days) which was initiated at 9:00 AM on 03/14/13 and concluded at 9:00 PM on 03/23/13. The MAR indicated [REDACTED]. The tays) which was initiated at 9.00 AM of 0.5/14/13 and coincided at 9.00 FM of 0.5/25/15. The MAK lindicated [REDACTE resident's clinical record revealed the order was given by the physician on 0.3/14/13, and review of the pharmacy's shipping manifest revealed the medication was delivered to the facility on [DATE] (toward the end of the day). At least the first three doses would have been obtained from a source other than the prescription order. However, inspection of the resident's medication drawer revealed the prescription box was still present in the drawer, that the package was labeled as having contained 30 capsules, was dispensed on 03/14/13, and still contained 5 capsules, even though the duration of therapy had concluded on 03/23/13, thereby indicating the resident could have failed to receive up to 5 of 30 ordered doses. Interview on 03/28/13, with KMA #3 revealed the resident's five extra capsules of Clindamycin probably came from the E-Box. Interview on 04/03/13 at approximately 10:00 AM with the Acting DON and the CNE revealed they were unable to obtain evidence that staff had obtained any doses of Clindamycin for Resident #3 from the E-Box. Review of records at the facility's backup pharmacy revealed no Clindamycin had been provided to Resident #3. Review of the facility's policy related to use of the E-Box (Policy #3.4, Emergency Pharmacy Service and Emergency Kits) revealed that staff did not consistently follow the policy. For example: A) Item #8 of the policy stated that upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on the emergency kit log. One copy of this information should be

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Previous Versions Obsolete Page 37 of 59

PRINTED:3/30/2014 FORM APPROVED

| | _ | | OMB NO. 0938-0391 |
|----------------------------------|--|---|--|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
| DEFICIENCIES | / CLIA | A. BUILDING | COMPLETED |
| AND PLAN OF | IDENNTIFICATION | B. WING | 04/09/2013 |
| CORRECTION | NUMBER | | |
| NAME OF BROWNER OF CHI | 185337 | CTREET ADDRESS CITY | CTATE ZID |
| NAME OF PROVIDER OF SUI | | STREET ADDRESS, CITY, S | STATE, ZIP |
| LEE COUNTY CARE & REH | ABILITATION CENTER | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| For information on the nursing l | nome's plan to correct this deficien | cy, please contact the nursing home or the state survey agency. | |
| (X4) ID PREFIX TAG | • | DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED | RV EUL DECULATORY |
| (A4) ID TREFIX TAG | OR LSC IDENTIFYING INFOR | | BIT CEE REGUEATOR I |
| F 0425 | (continued from page 37) | · | |
| | emergency kit until it is schedule | cy with the original prescriber order or refill request form and pl d for exchange. B) Item #9 stated that use of emergency medicat ever, that was not done as evidenced by the March MARs for Re | tions was to be noted on |
| F 0425 | immediately faxed to the pharma emergency kit until it is schedule the resident's current MAR. How Safely provide drugs and other in emergencies, by a licensed pl **NOTE- TERMS IN BRACKET Based on observation, interview acquiring, receiving, and adminis residents (Residents #3 and #9) a of practice regarding the adminis for receiving nourishment and or the facility failed to follow its pol and account for all medications renourishment and oral medications renourishment and oral medications resident was to receive six oral do 150 mg, and a Multivitamin with tablets, and then mix the resultan placement of the resident's tube, approximately 30 milliliters (ml) contents of two fish oil capsules a then administered the mixture of liberal post-flush with more wate consisting of a can of Jevity 1.2. revealed no evidence of a physici medications via feeding tube (Pol stated, Medication administration are known compatibility problem giving the medications was accepadministered the medications via having been told by other staff for administered the medications via having been told by other staff for administered the medications via red 103/28/13 at approximately 20 the Seasons Unit, Resident #9 was twice daily) for a urinary tract inf (Medication Administration Rec at 9:00 AM, and that all 20 order order was posted on 03/15/13, an 03/16/13. The time of delivery wobtained from a source other thar audited and revealed that Residen 03/15/13 for 20 capsules, and alticapsules, indicating the resident r 03/28/13, with KMA #3 concerni remained in the drawer, and state E-Box or in some cases by orderi interview, the unit's E-Box was in aide explained that when removit the top (white) copy being placed placed in a receipt box (located n contained some yellow copies for Resident #9. On 04/03/13 at appr Acting Director of Nursing (DON (e.g., usage reports) that any dose placed in a receipt box (located n contained some yellow copies for sease by orderi interview, the unit's E-Box was in aide explained that a daily per diem the B-B | d for exchange. B) Item #9 stated that use of emergency medicate ever, that was not done as evidenced by the March MARs for Resimilar products available, which are needed every day and | tions was to be noted on esidents #3 and #9. Y** Issure the accurate venty-nine sampled ollow accepted standards idents with feeding tubes esident D). In addition, and failed to monitor: 1. Resident D received 02/13 at 9:30 AM, the Img, Namenda 10 mg, Zantac vas observed to crush the four the interest of the tube with age forms (the liquid rition of water. The nurse imately 30 ml) followed by a inistering a bolus feeding D's clinical record ted to administration of Item #10 of the policy en if required if there one flush before and after ver, medications should be th LPN #4 revealed she tilty policy, but noted a standard was now to extend by the physician. 2. (MARs) for residents living on robid 100 mg (one capsule and 9:00 PM, and the MAR M and concluded on 03/25/13 revealed the Macrobid om the pharmacy on ent's initial two doses were linit medication cart was used by the pharmacy on to explain why the 12 capsules he use of the facility's tring the course of the Macrobid obtained for the Administrator #2, the ere unable to locate any proof lent #9. On 04/03/13 at 2:40 staff usually failed to a most instances any rposes. He further most items taken from the first impossible to er, he did speculate that, tech could have placed first two doses of ince of the 12 capsules. As a sident #9 had no acced to a prescription at he Seasons Unit, Resident #3 capsule 3 times daily for 10 IAR indicated [Resident #3 capsule 3 times daily for 10 IAR indicated [Resident #3 capsule 3 times daily for 10 IAR indicated [Resident was a she |
| | E-Box (Policy #3.4, Emergency I policy. For example: A) Item #8 kit, the nurse documents the med immediately faxed to the pharmaemergency kit until it is schedule | in had been provided to Resident #3. Review of the facility's po Pharmacy Service and Emergency Kits) revealed that staff did no of the policy stated that upon removal of any medication or supp ication or item used on the emergency kit log. One copy of this is cy with the original prescriber order or refill request form and pl d for exchange. B) Item #9 stated that use of emergency medical | ot consistently follow the bly item from the emergency information should be laced within the resealed tions was to be noted on |
| F.0401 | | ever, that was not done as evidenced by the March MARs for Re | |
| F 0431 | to accepted professional standa | perly mark/label drugs and other similar products according rds. and record review, it was determined that the facility failed to st | • |

Facility ID: 185337

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| | | | | OMB NO. 0938-0391 |
|-------------------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCT A. BUILDING | ΓΙΟΝ | (X3) DATE SURVEY COMPLETED |
| AND PLAN OF | IDENNTIFICATION | B. WING | | 04/09/2013 |
| CORRECTION | NUMBER | | | 04/05/2015 |
| | 185337 | | I | |
| NAME OF PROVIDER OF S | | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & RE | EHABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| For information on the nursin | g home's plan to correct this deficien | ncy, please contact the nursing hon | ne or the state survey agency. | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIE MATION) | ENCY MUST BE PRECEDED B' | Y FULL REGULATORY |
| F0431 | (continued from page 38) biologicals under acceptable tem vials of insulin inside treatment of standards of practice. The finding #4.1, Storage of Medications) rev stored in the refrigerator until op Opened insulin pens must be ston pharmacy instructed staff through the date of opening on either the discard/replace any unused portic Seasons Unit Medication Room Registered Nurse (RN) #7 reveal temperature. Inspection of the tre date of opening, and all determin it was the facility's policy to refri then use the insulin for up to 28 medication refrigerator revealed facility's policy regarding insulin in the treatment cart immediately vary from the one used on the Se insulin, most having been recend box; all were determined to be w unopened vial of NovoLog Insul dispensed on 03/05/13. Based on stored outside of refrigeration for 2:00 PM on 04/04/13, the C Unit delivered by the pharmacy imme refrigerator revealed no storage or numerous open vials of insulin, t and all within the 28-day timefra based on the nurse interview, hav The vials included four unopened vials dispensed on 03/03/13). In unopened vial of NovoLog Insul approximately 2:45 PM on 04/04 etc. The pharmacist stated he wo provide staff in-servicing on the he had placed the majority of the approximately 2:00 PM, an inspe now under storage in the refriger stored in the refrigerator. As earl more days, so their potencies co | perature parameters. It was deternants and not under refrigeration per sinclude: Review of the of the favealed the storage of insulin, Item ened. The opened insulin vial may red at room temperature. Although hits labeling of insulin vials that, bottle or outer box of the insulin, item on of the insulin after 28 days of orevealed several unopened vials of insulin well attended the presence the death of the vials prior to use, to dat days of opening. Observation on 0 no vials of insulin. During an intensional process of the vials prior to use, to dat days of opening. Observation on 0 no vials of insulin. During an intensionant of the vials prior to use, to dat days of opening. Observation on 0 no vials of insulin. During an intensionant of the vials of insulin. During an intensionant of the vials of the vials of the vials prior to use, to dat the vials of insulin. During an intensional process. Unit. Inspection of the treat y dispensed by the pharmacy, and tithin the 28-day timeframe for coin which had been dispensed on 0 observation and the nurse's intervials of insulin of any kind. However, in the majority having been recently one for acceptable use. However, it is been stored outside of refrigeration of the vials of NovoLog Insulin assignaddition, Resident B had an unope in (dispensed on 02/27/13). Interviv/13 revealed staff should be storinuld follow up regarding the use an issue. Further interview on 04/05/10. C Unit's unopened insulin (found ection of the C Unit refrigerator reator. However, the six vials earlier noted, all of those vials had beat lid not be ensured. | er facility policy and in accordanc cility's policy related to medicatic #12 instructed staff that Insulin probe stored in the refrigerator or at a not specified in the facility polic upon opening new vials of insulin and then store it at room temperat pening. Observation on 04/04/13 insulin stored in the unit's treatment can of several opened vials of insulin me and were appropriate for cont te them upon opening and store ur 4/04/13 at 1:30 PM, of the B Unit rview with RN #6, she stated she procedure on the B Unit to place to the thin the state of the state | e with professional on storage (Policy roducts should be room temperature. y, the provider , staff was to note ure and at 11:00 AM, of the ator. Interview with rt, at room , all noted with the inued use. RN #7 stated urefrigerated, and 'Medication Room was not sure of the vials of insulin re used on the B Unit did several opened vials of bottle or the exterior #13 was noted to have an ed vial of the same, ened vial is had been cility policy. At tice to place all insulin o of the unit's vealed the storage of th noted opening dates, also observed which, unacceptable for use. used on 02/03/13 and two is sed on 03/06/13) and an Pharmacist at ator prior to using, ated he planned to the Pharmacist revealed erator. At vials of insulin were d B) were among those |
| F 0431 | to accepted professional standar Based on observation, interview, biologicals under acceptable tem vials of insulin inside treatment of standards of practice. The finding #4.1, Storage of Medications) restored in the refrigerator until op Opened insulin pens must be stored in the refrigerator until op Opened insulin pens must be stored in the date of opening on either the discard/replace any unused portice seasons. Unit Medication Room in Registered Nurse (RN) #7 reveal temperature. Inspection of the tredate of opening, and all determinit was the facility's policy to refrithen use the insulin for up to 28 of medication refrigerator revealed facility's policy regarding insuling in the treatment cart immediately vary from the one used on the Seinsulin, most having been recently box; all were determined to be unopened vial of NovoLog Insulingtones on 03/05/13. Based on stored outside of refrigeration for 2:00 PM on 04/04/13, the C Unit delivered by the pharmacy immerefrigerator revealed no storage on unwerous open vials of insulin, than all within the 28-day timefra based on the nurse interview, has The vials included four unopened vial of NovoLog Insulingtones on 03/03/13). In unopened vial of NovoLog Insulingtones of the paramacist stated he wo provide staff in-servicing on the he had placed the majority of the approximately 2:00 PM, an inspenow under storage in the refriger on the proximately 2:00 PM, an inspenow under storage in the refriger | and record review, it was determined and another than the perature parameters. It was determined and the perature parameters and not under refrigeration person to the person of the insulin. Item ened. The opened insulin vial may red at room temperature. Although its labeling of insulin vials that, bottle or outer box of the insulin, on of the insulin after 28 days of or revealed several unopened vials of ed that opened vials of insulin we attend to the presence that the person of the insulin after 28 days of opening. Observation on 0 no vials of insulin. During an interest of the person of the treat of the person of the treat of the person of the treat of the person | ned that the facility failed to store nined that staff on Units B and C ver facility policy and in accordance cility's policy related to medicatic #12 instructed staff that Insulin probe stored in the refrigerator or at a not specified in the facility policy upon opening new vials of insulin and then store it at room temperat pening. Observation on 04/04/13 insulin stored in the unit's treatment ca of several opened vials of insulin me and were appropriate for cont tee them upon opening and store ur 4/04/13 at 1:30 PM, of the B Unit roise with RN #6, she stated she procedure on the B Unit to place. The nurse admitted the procedure ment cart on the B Unit to place. The nurse admitted the procedure the upon opening dates noted on the litinued usage. However, Resident 1/19/13 as well as another unopen evew, it was determined both unop eptable for resident use per the far RN #4 stated it was Unit C's pracad of the refrigerator. Observation spection of the treatment carts relispensed by the pharmacy, all wis ix unopened vials of insulin dispeniew with the facility's Consultant gunopened insulin in the refriger di storage of insulin. He further staff at 1:30 PM, with the Consultar on the previous day) in the refrigerator ofted (involving Residents A and roted (involving Residents A). | was storing unopened e with professional on storage (Policy roducts should be room temperature. y, the provider ,, staff was to note ure and at 11:00 AM, of the ator. Interview with rt, at room , all noted with the inued use. RN #7 stated arefrigerated, and 'Medication Room was not sure of the vials of insulin re used on the B Unit did several opened vials of bottle or the exterior #13 was noted to have an ed vial of the same, ened vials had been cility policy. At stice to place all insulin to of the unit's vealed the storage of th noted opening dates, also observed which, unacceptable for use. used on 02/03/13 and two used on 03/06/13) and an Pharmacist at ator prior to using, ated he planned to the Pharmacist revealed erator. At vials of insulin were d B) were among those |
| F 0469 | Make sure there is a pest contro pests. | ol program to prevent/deal with FS HAVE BEEN EDITED TO PR | | k |

Facility ID: 185337

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:3/30/2014 FORM APPROVED OMB NO 0938-0391

| | | | | OMB NO. 0938-0391 |
|--------------------------------|---|---|--|--|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUC | TION | (X3) DATE SURVEY COMPLETED |
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | | |
| CORRECTION | NUMBER | D. WING | | 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SU | PPLIER | • | STREET ADDRESS, CITY, ST. | ATE, ZIP |
| LEE COUNTY CARE & REI | HABILITATION CENTER | | 246 EAST MAIN STREET | |
| For information on the nursing | home's plan to correct this deficien | vay places contact the pursing her | BEATTYVILLE, KY 41311 | |
| (X4) ID PREFIX TAG | 1 . | | ENCY MUST BE PRECEDED B' | V FIII I REGIII ATORV |
| (X4) ID I KELIA TAG | OR LSC IDENTIFYING INFOR | | ENCT MOST BETRECEDED B | I FOLL REGULATOR I |
| F 0469 | program to ensure the facility wa 04/03/13. The findings include: A company would provide structur revealed treatment for [REDACT PM and on 04/03/13 at 10:05 AN windowsills and baseboards. A r interior of the building had been were reported to Maintenance on Housekeeping Supervisor on 04/0 cleaned once per month. Further in resident rooms A-1, A-2, and Maintenance Director had treated | is free of pests. Ants were observed a review of the facility pest control al pest control services as need to TEDJ. Observations of resident rowal revealed small black ants, too meview of monthly pest control invitreated for [REDACTED]. A revi. 03/29/13 when the room had bee 03/13 at 5:15 PM, revealed reside interview revealed the Housekeep A-6. An interview with the Maintol 1 rooms A-1 and A-6 for ants on 0 | and the facility failed to have an ead in resident rooms A-1, A-2, and ol contract dated 11/01/06 revealer effectively control ants. Further rooms conducted during environmer umerous to count, in resident room oices dated 02/15/13 and 03/27/13 ew of a deep cleaning schedule for the cleaned by Housekeeping. An irent rooms were cleaned daily by Hoing Supervisor was not aware tha enance Director on 04/03/13 at 5:303/29/13, but was not aware the an | A-6 on 04/02/13 and 1 a pest control view of the contract ttal tours on 04/02/13 at 4:00 as A-1, A-2, and A-6 near i revealed no evidence the r room A-1 revealed ants tterview conducted with the busekeeping and were deep t ants were still present 10 PM, revealed the ts were still in the |
| F 0469 | ants in the room. According to the control company's representative that he had not contacted the pest Make sure there is a pest contropests. **NOTE-TERMS IN BRACKET | ne Maintenance Director, he toure when the interior of the facility of t control company regarding the a ol program to prevent/deal with ITS HAVE BEEN EDITED TO PI | ROTECT CONFIDENTIALITY* | I toured with the pest unce Director stated t for the ants. |
| | Based on observation, interview, program to ensure the facility wa o4/03/13. The findings include: A company would provide structur revealed treatment for [REDACT] PM and on 04/03/13 at 10:05 AM windowsills and baseboards. A rainterior of the building had been were reported to Maintenance on Housekeeping Supervisor on 04//cleaned once per month. Further in resident rooms A-1, A-2, and Maintenance Director had treated resident rooms. Additional intervants in the room. According to the control company's representative | and record review it was determined free for the state of pests. Ants were observed a review of the facility pest control pest control services as need to tend for the state of the state | and the facility failed to have an ed in resident rooms A-1, A-2, and ol contract dated 11/01/06 revealed effectively control ants. Further rooms conducted during environmer umerous to count, in resident room roices dated 02/15/13 and 03/27/13 iew of a deep cleaning schedule for cleaned by Housekeeping. An in ent rooms were cleaned daily by Hiping Supervisor was not aware tha enance Director on 04/03/13 at 5:303/29/13, but was not aware the an rector had not treated room A-2 not d monthly to identify concerns and was treated monthly. The Maintenants because he had ant bait to treat | ffective pest control A-6 on 04/02/13 and 1 a pest control eview of the contract tal tours on 04/02/13 at 4:00 s A-1, A-2, and A-6 near revealed no evidence the r room A-1 revealed ants tetrview conducted with the busekeeping and were deep t ants were still present 10 PM, revealed the ts were still in the or was he aware there were I toured with the pest unce Director stated |
| F 0490 | Be administered in an acceptab | le way that maintains the well-b | peing of each resident . | |
| | the facility failed to be administe sampled residents (Residents #1, ensure policies and procedures w Administration and to the approp facility investigations; and failed (Refer to F223, F225, F226, and prevention were developed and ir residents in the facility. Immedia Immediate Jeopardy was determi Practices (F223, F225, and F226, CFR 483.13 Resident Behavior a Jeopardy on 03/01/13 and 03/29/ acceptable credible Allegation of on 04/17/13. The State Survey A acceptable AOC, with remaining F225 and F226 - S/S E) and 42 C a Plan of Correction and monitor include: Review of the facility's a report and thoroughly investigate reasonable suspicion of criminal reported immediately to the charwer to be notified immediately suspicion of an incident of abuse appropriate. The policy also reveabuse involving staff members, r Administrator/designee would m grievances presented to them; an wellbeing following the incident DON and/or Social Worker woul or direct contact related to the all 02/22/13, revealed on the mornin crying, wanting to go to bed. Stat due to the resident yelling, whini teach the resident a lesson. Intervor notify appropriate facility pers care and remained on the floor w revealed LPN #1 was innerviewed and stat behavior. Facility staff interview with consisted of reviewing witness at interviewing LPN #1, the Charge statements describing the LPN's oriented resident had reported with concluded that staff might have r determine if LPN #1 had abused disciplinary action was taken aga facility's policy revealed a thorou involving staff members, residen | red in a manner that maintained the 44, #19, #29, #30, and #31). The rere developed/implemented to ensite the state Agencies; failed to ensite ensure thorough investigations for the state Agencies; failed to ensite ensure thorough investigations for the properties of the state | estigation and policy and procedur he highest physical well-being for facility failed to have an effective sure staff immediately reported al sure all residents were protected from the shad been conducted related to about the to ensure facility policies/proced to cause, serious injury, harm, imfied on 03/01/13 and 03/24/13 religiong at 42 CFR 483.13 Resident ion (F490 and F520), with Substation of F490 and F490 an | six of twenty-nine system in place to legations of abuse to om abuse during use allegations. dures related to abuse pairment, or death to ated to abuse. The Behavior and Facility and Quality of Care at 42 field of the Immediate oing. The facility provided an of the Immediate Jeopardy 04/23/13, as alleged in the fractices (F223 - S/S D and ty develops and implements ties. The findings to immediately sident's property or not was to be ordinator, as appropriate, 1, Any report or coordinator, as alleged incidents of incident; the concerns, and ediate safety and diministrator and/or als from direct care giving vestigation, dated the nurses' station at the resident to bed ent that she was going to ents in the facility in charge of resident 1). Further review accility's investigation, ord for the resident's had overheard the gation abuse could not of the alleged abuse egional staff, and taff interviews and witness is aware an alert and iously. However, he had to a firm conclusion or , and no further r, review of the dents of abuse ent; the |

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet Page 40 of 59

| | TH AND HUMAN SERVICES E & MEDICAID SERVICES | | PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF | | | ESS, CITY, STATE, ZIP |
| LEE COUNTY CARE & R | EHABILITATION CENTER | 246 EAST MAI BEATTYVILLI | |
| | <u> </u> | cy, please contact the nursing home or the state sur | , , , |
| (X4) ID PREFIX TAG | OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIENCY MUST BE MATION) | PRECEDED BY FULL REGULATORY |
| F 0490 | (continued from page 40) grievances presented to them. Fur facility's policy did not instruct st the policy stated only the Adminiremoval of individuals from direct the facility's first AOC, alleging it DON, Social Worker/Abuse Coofurther stated that the Chief Nurse through the present time, with no he/she had reported an allegation months prior when the incident of and the resident was afraid of the AM revealed the allegation was reprovide direct care because the faconducted. There was no evidence AOC that this investigation was reprovide direct care because the faconducted. There was no evidence AOC that this investigation was reprovide direct care because the facility and was not available for was also acting as the facility's A further interview on 04/05/13 at 7 he could not recall the resident's interview and review of the facilian allegation of abuse involving I dated 04/01/13, revealed on 03/2/88 to provide further care for the interviewed Resident #4, the RN, Based on this information, the facognitive ability. Interview with however, did not notify the Admin Corporate Nurse Consultant queses 6:40 PM, and on 03/29/13 at 10:2 Administrator #2 stated the DON to inform him of the allegation of stated, In my heart of hearts I have and reportable, even before the in alleging removal of jeopardy on (Worker/Abuse Coordinator, had residents. In addition, according track/trend all allegations of abuse revealed four other allegations of staff and there was no evidence the thoroughly investigated, or that fa the facility's abuse log revealed interview with Administrator #2 failures to investigate, report, and Administrator #2 stated he was no 04/17/13, which alleged the remo Chief Operating Officer performs allegations. Administrator by 14/06 and Regional Team on 04/12/13 to the app allegations. The Chief Nurse Executive reporting to the Office on the report of the state here of the facility of the state here of the province of the p | ther interview with Administrator #1 on 03/05/13 and for to immediately remove the alleged perpetrator is strator and/or DON and/or Social Worker would met care giving or direct contact related to the alleged emoval of jeopardy on 03/06/13, revealed all staff, dinator were re-educated beginning 03/04/13, on the extraction of the property of the pro | from direct resident care. However, alake any immediate decisions related to the l or suspected abuse. 2. A review of including the Administrator, the he revisions of the abuse policy. The AOC as that occurred from June 2012 dent #29 on 04/05/13, the resident stated ordinator approximately two to three aber touched her breast inappropriately (Abuse Coordinator on 04/09/13 at 11:09 he alleged perpetrator continued to investigation had not been st investigation had not been st investigation sa stated in the and the resident was not protected, ger employed as Administrator of the the Vice President of Operations who dent involving Resident #29. However, lling him about the incident; however, or that resident's concern. 3. //13 the Administrator was notified of A review of a facility's investigation esident and the resident float on was review of a facility's investigation esident and the resident float on was review of a facility's score of 8 or higher. Resident #4's moderately impaired ame aware of the allegation on 03/24/13; three days later, when the diministrator #2 on 03/28/13 at 2:00 PM, the incident on 03/27/13 around 5:40 PM, tation related to the incident and forgot 2 did not think it was reportable. He . I just didn't feel it was true facility's second AOC, dated 04/05/13, ty Administrator, DON, and Social estigation, reporting, and protection of aintained by the Administrator to orker/Abuse Coordinator on 04/09/13 and #31 had been reported to facility priate State Agencies, had been tential abuse. In addition, review of ts #19, #29, #30, and #31. An s not effective to identify facility allegation was reported. ty provided an acceptable (AOC) on he following: On 04/11/13 and 04/12/13, the and computer for any files related to nitial reports were submitted on the float on the float of the alleged abuse in 04/05/13. An investigation has been ation regarding abuse, completed by an e-educated by the Department Directors et a daily onsolve with the Chief Operating Officer gations, grievance reports, incident |

If continuation sheet Page 41 of 59 FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 Previous Versions Obsolete

DDINTED:3/30/2014

| | DELARTMENT OF HEALTH AND HUMAN SERVICES | | | | 1 KIN 1 ED.3/30/2014 |
|---|--|--------------------|---|---|---|
| | CENTERS FOR MEDICARE & | MEDICAID SERVICES | | | FORM APPROVED |
| | | | | | OMB NO. 0938-0391 |
| | DEFICIENCIES AND PLAN OF | / CLÍA | (X2) MULTIPLE CONSTRUCT A. BUILDING B. WING | TION | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | | 185337 | | | |
| ı | NAME OF PROVIDER OF SUPI | PLIER | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| | LEE COUNTY CARE & REHA | ABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| | For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| 1 | | | | | |

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION

F 0490

(continued... from page 41)
Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and Paginal Staff Page 201 at 1:54 PM with Activity Assistant #1 confirmed they were re-educated by Department Directors and/or Regional Staff. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the DON; and at 12:38 PM with the review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the DON; and at 12:38 PM with the Interim Social Services Director revealed the Independent Contractor did provide them with one on one education related to protection, reporting, and investigation of allegations of abuse prior to 04/12/13. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. days a week, basis.

---During a complaint investigation (KY) conducted in conjunction with the revisit, an additional example of noncompliance was identified. Interview, review of the facility investigation and review of the facility's Abuse, Neglect and Misappropriation Policy, revealed the facility failed to be administered in a manner that maintained the highest physical well-being for Resident #32. The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure allegations of abuse were reported to the State Survey Agency in a timely manner. (Refer to F225 and F226.) A review of the facility's Abuse, Neglect and Misappropriation policy, revised March 2013 and effective April 2013, revealed, all allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with officials in accordance with State law through established guidelines. A review of the facility's investigation report revealed on 04/17/13, at approximately 10:50 AM, Licensed Practical Nurse (LPN) #5 reported to the facility's administration that Kentucky Medication Aide (KMA) #6 reported an allegation that had been made against her (KMA #6). According to the facility's investigation, while KMA #6 was providing care to Resident #32 that morning (04/17/13), the resident told KMA #6 that she was pulling the resident's hair and trying to kill the resident. According to documentation on the report, the alleged perpetrator (KMA #6) was immediately suspended and an investigation was initiated. The report further revealed the allegation was reported to the State Survey Agency on 04/18/13 at 5:52 PM (at inneframe of 31 hours after the allegation had been reported to the regulatory guidelines indicated reporting of an allegation of abuse ought not to exceed 24 hours, and had interpreted the statement to mean the facility. Interview on 04/22/13 at 1:58 PM that the facility was a 24-hour business. Administrator #2 ack ---During a complaint investigation (KY) conducted in conjunction with the revisit, an additional example of noncompliance 04/22/13 at 1:58 PM that the facility had not reported the incident until 04/18/13 at 5:52 PM even though the facility staff had reported the incident to Administration at approximately 10:50 AM on 04/17/13. According to the Administrator, he thought the facility had until midnight the day after an incident had been reported to make the report and stated he thought the 24-hour timeframe was from midnight on the day the incident occurred to midnight the day after the incident

Be administered in an acceptable way that maintains the well-being of each resident .

Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to be administered in a manner that maintained the highest physical well-being for six of twenty-nine sampled residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure staff immediately reported allegations of abuse to Administration and to the presented State Administration and the procedure of the Administration and to the appropriate State Agencies; failed to ensure all residents were protected from abuse during facility investigations; and failed to ensure thorough investigations had been conducted related to abuse allegations. facility investigations; and failed to ensure thorough investigations had been conducted related to abuse allegations. (Refer to F223, F225, F226, and F520.) The Administration's failure to ensure facility policies/procedures related to abuse prevention were developed and implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated, Any report or suspicion of an incident was to be report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated, Any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, Any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 1. Interview and review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying, wanting to go to bed. Staff reported LPN #1, the Charge Nurse, would not allow staff to assist the resident to bed due to the resident yelling, whining, and crying. One staff member reported LPN #1 made the comment that she was going to teach the resident a lesson. Interviews revealed staff did not immediately take action to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, and LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse had occurred). Further review care and remained on the floor with residents until 12:30 PM (five hours after the abuse had occurred). Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. During the facility's investigation, LPN #1 was interviewed and stated she wanted Resident #1 to stay at the nurses' station to be monitored for the resident's behavior. Facility staff interviewed other residents on the unit and one other resident reported he/she had overheard the LPN say negative things about another resident. The investigation further stated based on the investigation abuse could not be substantiated. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. Administrator #1 acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson and he was aware an alert and oriented resident had reported witnessing LPN #1 be inappropriate and rude to another resident previously. However, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or

FORM CMS-2567(02-99) Previous Versions Obsolete

F 0490

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCT A. BUILDING | TION | (X3) DATE SURVEY COMPLETED |
|------------------------------|---|--|--|--|
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER 185337 | B. WING | | 04/09/2013 |
| NAME OF PROVIDER OF SU | | | STREET ADDRESS, CITY, STA | TE, ZIP |
| LEE COUNTY CARE & REF | HABILITATION CENTER | | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| | home's plan to correct this deficient | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | | ENCY MUST BE PRECEDED BY | FULL REGULATORY |
| F 0490 | (continued from page 42) determine if LPN #1 had abused I disciplinary action was taken agai facility's policy revealed a thorou involving staff members, resident Administrator/designee would ma grievances presented to them. Fur facility's policy did not instruct st the policy stated only the Admini removal of individuals from direct the facility's first AOC, alleging r DON, Social Worker/Abuse Coor further stated that the Chief Nurse through the present time, with no he/she had reported an allegation months prior when the incident of and the resident was afraid of the AM revealed the allegation was n provide direct care because the faconducted. There was no evidence AOC that this investigation was n Administrator #1, who was the facility and was not available for was also acting as the facility's A further interview of the facili an allegation of abuse involving I dated 04/01/13, revealed on 03/2/#8 to provide further care for the interviewed Resident #4, the RN, Based on this information, the facognitive ability. Interview with thowever, did not notify the Admi Corporate Nurse Consultant quest 6:40 PM, and on 03/29/13 at 10:2 Administrator #2 stated the DON to inform him of the allegations of abuse revealed four other allegations of abuse. Da | Resident #1. Therefore, the allegatinst the LPN concerning the allegatinst the rinterview with Administrator aff to immediately remove the allestrator and/or DON and/or Social to care giving or direct contact relatemoval of jeopardy on 03/06/13, idinator were re-educated beginning the Executive reviewed all incidents concerns. However, during an int of abuse to the facility's Social Woccurred, Resident #29 alleged that staff person. An interview with the or reported to the appropriate Staticity felt it was not abuse, event the enditity in the subseal elegation diministrator on record during this interview. Interview on 04/05/13 dministrator, revealed he was not 230 PM, revealed he did recall Actame and did not ask additional quy's investigation dated 04/01/13 r RN #8 and Resident #4 that occur 1/13, Resident #4 allegat RN #8 resident and did not want RN #8 resident and did not want RN #8 treatment and did not want RN #8 to the DON on 04/02/13 at 8:45 PM mistrator, or initiate an investigation he be regarding the incident. 5 AM, and 4:11 PM revealed he tinformed him she had forgotten to abuse. Further interview revealed contry for the abuse allegations in one netrained on abuse protocols to the AOC, an abuse investigations. However, interview with the faresident abuse involving Resident abuse involving Resident elegations to the AOC, an abuse investigation in other protect Residents #19, #29, #30, at aware of these allegations of abval of Immediate Jeopardy on 04/d a document search of the Adminition, or neglect. There were six fad not been thorough; investigation in the charm of the Adminition, and investigation of allegative completed a review of all allegation of allegative completed a review of all allega | tion of abuse was unsubstantiated, ed abuse to Resident #1. However dimmediately for all alleged incide joetential knowledge of the incide igate and address alleged reports, or #1 on 03/05/13 at 4:25 PM revea ged perpetrator from direct reside Worker would make any immediated to the alleged or suspected abstevealed all staff, including the Ading 03/04/13, on the revisions of the and investigations that occurred ferview with Resident #29 on 04/07 orker/Abuse Coordinator approxing a male staff member touched her be Social Worker/Abuse Coordinator approxing a male staff member touched her and investigations that occurred ferview with Resident #29 on 04/07 orker/Abuse Coordinator approxing a male staff member touched her as male staff member touched her as male staff member touched her time, was no longer employed as their review of past investigations was not reported, and the resident time, was no longer employed as at 6:05 PM, with the Vice Presider aware of the incident involving Relministrator #1 telling him about the sestions related to that resident's crevealed on 03/27/13 the Administred on 03/24/13. A review of a factory was mean to the resident and the resident and the resident based on Resident #4's more revealed she became aware of the on until 03/27/13, three days later, Interview with Administrator #2 of became aware of the incident on 0:0 start an investigation related to the Administrator #2 did not think it ille I've been here. I just didn't feel A review of the facility's second cluding the facility Administrator had from further potential abuse. In a nivolving Residents #19, #29, #30, and #31 had been the proper second work and computer for illes identified, which had not been ded, in which the initial reports were inistrator's office and computer for illes identified, which had not been ded, in which the initial reports were used. In which the initial reports were used of the second of | preview of the ents of abuse int; the concerns, and led he was not aware the int care. However, the decisions related to the use. 2. A review of liministrator, the end abuse policy. The AOC rom June 2012 5/13, the resident stated mately two to three breast inappropriately or on 04/09/13 at 11:09 rator continued to d not been as stated in the was not protected. Administrator of the at of Operations who esident #29. However, the incident; however, oncern. 3. rator was notified of tilty's investigation sident id not want RN in. The facility core of 8 or higher. deerately impaired allegation on 03/24/13; when the in 03/28/13 at 2:00 PM, 3/27/13 around 5:40 PM, the incident and forgot was reportable. He it was true AOC, dated 04/05/13, DON, and Social ing, and protection of Administrator to dinator on 04/09/13 in reported to facility cies, had been addition, review of and #31. An identify facility ported, ceptable (AOC) on 04/11/13 and 04/12/13, the any files related to reported to a submitted on e of the alleged abuse vestigation has been buse, completed by an integration by the complete of the complete of the alleged abuse vestigation has been buse, completed by an integration of the trems of the complete of the alleged abuse vestigation for the trems of the complete of the alleged abuse vestigation for the trems of the complete of the vith adult in the resident is different instrator. Operating officer end and instrator of the vith adult in the cord on 04/05/13, and a will include to a care area, reports to do do no of the vith abuse investigation of the vith abuse investig |

FORM CMS-2567(02-99) Event ID: YL1011 Previous Versions Obsolete

| CENTERS FOR MEDICAR | RE & MEDICAID SERVICES | | PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 |
|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 195327 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF | 185337 SUPPLIER | STREET ADDE | RESS, CITY, STATE, ZIP |
| LEE COUNTY CARE & R | REHABILITATION CENTER | 246 EAST MAI BEATTYVILL | |
| For information on the nursi | ing home's plan to correct this deficien | cy, please contact the nursing home or the state su | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIENCY MUST BE MATION) | E PRECEDED BY FULL REGULATORY |
| F 0490 | Aide (SRNA) #8; at 10:53 AM w 11:27 AM with Licensed Practica Dietary Aide #2; at 12:05 PM with with SRNA #9; at 12:38 PM with Medication Aide #6; at 1:09 PM ' at 1:54 PM with Activity Assistar review and interview on 04/23/13 Interim Social Services Director 1 protection, reporting, and investig Officer on 04/23/13 at 2:12 PM a of all allegations of abuse receive Operating Officer revealed he had grievance reports, incident report Nurse Executive on 04/23/13 at 1 daily skin assessments onsite. Re the Director of Nursing; and at 12 occasions daily to review any abu investigation log daily to keep tra protected, and that the allegations | Review of post-test and interviews on 04/23/13 at ith Housekeeper #4; at 11:03 AM with Registered Il Nurse #4; at 11:37 AM with SRNA #5; at 11:45 h SRNA #7; at 12:12 PM with Registered Nurse # SRNA #1; at 12:49 PM with Certified Medication with SRNA #1; at 12:49 PM with Certified Medication with SRNA #1; at 12:17 PM with Maintenance Worth #1 confirmed they were re-educated by Departm at 2:38 PM with Administrator #2; at 12:21 PM viewealed the Independent Contractor did provide the pation of allegations of abuse prior to 04/12/13. Int of the Chief Nurse Executive at 11:53 AM revealed by the facility and no concerns were identified. If assisted in completing daily reviews, seven (7) ds., and daily resident interviews with no concerns 1:53 AM and the Regional Nurse Consultant at 11 cord review and interview on 04/23/13 at 2:38 PM 2:38 PM with the Interim Social Services Director see investigations that were reported. The Adminisc of all abuse allegations to ensure they were invested by PM revealed she assists in reviewing the abuse allegations to reviewing the abuse. | Nurse #5; at 11:16 AM with Housekeeper #5; a AM with Dietary Aide #1; at 11:54 AM with 4; at 12:20 PM with SRNA #12; at 12:28 PM n Aide #1; at 1:41 PM with Laundry Worker #1; at 1:41 PM with Laundry Worker #1; ar nent Directors and/or Regional Staff. Record with the DoN; and at 12:38 PM with the Den with one on one education related to terview with the Chief Operating ed, by 04/10/13, they had completed a review Further interview with the Chief ays a week, of abuse allegations, dentified. Interview with the Chief 1:32 AM revealed they were reviewing all with Administrator #2; at 12:21 PM with revealed they were meeting on numerous strator stated he utilized an abuse estigated, the residents were Agencies. Interview with the Chief |
| | During a complaint investigativas identified. Interview, review Misappropriation Policy, revealed well-being for Resident #32. The were developed/implemented to e (Refer to F225 and F226.) A revieffective April 2013, revealed, all immediately to the charge nurse a through established guidelines. A 10:50 AM, Licensed Practical Nu #6 reported an allegation that had was providing care to Resident #/hair and trying to kill the resident immediately suspended and an in State Survey Agency on 04/18/13 administration of the facility). Intregulatory guidelines indicated re statement to mean the facility couthe time frame was in business he 04/22/13 at 1:58 PM that the facility fad reported the incident to thought the facility had until mid- | on (KY) conducted in conjunction with the revisit of the facility investigation and review of the facil the facility failed to be administered in a manner facility failed to have an effective system in place ensure allegations of abuse were reported to the Stuw of the facility's Abuse, Neglect and Misappropal allegations of abuse involving abuse along with ind/or administrator of the facility along with office review of the facility's investigation report reveal ares (LPN) #5 reported to the facility's Administrative made against her (KMA #6). According to the study of the facility investigation report reveal as the morning (04/17/13), the resident told KMA. According to documentation on the report, the alwestigation was initiated. The report further reveal at 5:52 PM (a timeframe of 31 hours after the alle verview on 04/22/13 at 2:15 PM with the Chief Nuporting of an allegation of abuse ought not to excell the according to the facility was a 24-hour business. Admility had not reported the incident until 04/18/13 at Administration at approximately 10:50 AM on 04/18/11 as from midnight the day after an incident had been reported to as from midnight on the day the incident occurred | tity's Abuse, Neglect and that maintained the highest physical to ensure policies and procedures ate Survey Agency in a timely manner. riation policy, revised March 2013 and nijuries of unknown origin are reported itals in accordance with State law ed on 04/17/13, at approximately ion that Kentucky Medication Aide (KMA) he facility's investigation, while KMA #6 at the she was pulling the resident's leged perpetrator (KMA #6) was ed the allegation was reported to the seat Executive (CNE) revealed the rese Executive (CNE) revealed the riview further revealed the CNE thought nistrator #2 acknowledged in interview on 5:52 PM even though the facility (17/1/13. According to the Administrator, he onake the report and stated he |
| F 0490 | Based on interview, record review the facility failed to be administer sampled residents (Residents #1, ensure policies and procedures w. Administration and to the approp facility investigations; and failed (Refer to F223, F225, F226, and I prevention were developed and in residents in the facility. Immediat Immediate Jeopardy was determin Practices (F223, F225, and F226) CFR 483.13 Resident Behavior at Jeopardy on 03/01/13 and 03/29/acceptable credible Allegation of on 04/17/13. The State Survey As acceptable AOC, with remaining F225 and F226 - S/S E) and 42 C a Plan of Correction and monitors include: Review of the facility's a report and thoroughly investigate reasonable suspicion of criminal reported immediately to the chargwere to be notified immediately be suspicion of an incident of abuse appropriate. The policy also reveabuse involving staff members, readministrator/designee would magievances presented to them; and wellbeing following the incident DON and/or Social Worker would or direct contact related to the all 02/22/13, revealed on the mornin crying, wanting to go to bed. Staf due to the resident a lesson. Interv or notify appropriate facility persuare and remained on the floor wirevealed LPN #1 was immediatel | e way that maintains the well-being of each resive, and review of the facility's investigation and pole and in a manner that maintained the highest physic #4, #19, #29, #30, and #31). The facility failed to leave developed/implemented to ensure staff immediate State Agencies; failed to ensure all residents to ensure thorough investigations had been conducted to ensure thorough investigations had been conducted on the state Agencies; failed to ensure all residents to ensure thorough investigations had been conducted on the state Agencies; failed to ensure facility plantaged on was likely to cause, serious to eleopardy situations were identified on 03/01/13 ned to exist on 02/17/13 and is ongoing at 42 CFR 483.75 Administration (F490 and F50 and Facility Practices (F223, F225, and F226). The 13 and was informed on 04/09/13 with the facility gency (SSA) verified removal of the Immediate Jenoncompliance (AOC) on 04/17/13 with the facility gency (SSA) verified removal of the Immediate Jenoncompliance at 42 CFR 483.13 Resident Behav FR 483.75 Administration (F490 and F520 - S/S Es the effectiveness of systemic changes and quality buse policy, dated 01/2012, revealed it was the intallegations of mistreatment, neglect, abuse, misapact or intent. The policy stated, Any report or suspenurse, and the Administrator, Director of Nursing the charge nurse who receives the report. Furthe was to be immediately reported to the charge nurseled a thorough investigation was to be initiated in sidents, family, and/or visitors who had potential ske all reasonable efforts to investigate and addres that the resident was to receive measures to ensured and during the investigation process. The policy full make any immediate decisions related to the rereged or suspected abuse. 1. Interview and review of gof 02/17/13, after the morning meal, staff observed the process of the member reported LPN #1 the residents until 12:30 PM (five hours after the all that the residents until 12:30 PM (five hours after the all the residents until 12:30 PM | licy and procedures it was determined al well-being for six of twenty-nine have an effective system in place to iately reported allegations of abuse to were protected from abuse during cted related to abuse allegations. Ity policies/procedures related to abuse injury, harm, impairment, or death to and 03/24/13 related to abuse. The 483.13 Resident Behavior and Facility 20), with Substandard Quality of Care at 42 facility was notified of the Immediate eopardy was ongoing. The facility provided an alleging removal of the Immediate leopardy opardy on 04/22-04/23/13, as alleged in the ior and Facility Practices (F223 - S/S D and 3) while the facility develops and implements assurance activities. The findings tent of the facility to immediately propriation of resident's property or icion of an incident was to be gand Abuse Coordinator, as appropriate, er review revealed, Any report or e and/or Abuse Coordinator, as annediately for all alleged incidents of knowledge of the incident; the salleged reports, concerns, and re his or her immediate safety and urther stated the Administrator and/or loval of individuals from direct care giving of the facility's investigation, dated and the comment that she was going to in to protect residents in the facility continued to be in charge of resident buse had occurred). Further review tion. During the facility's investigation, |

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 Previous Versions Obsolete

LPN say negative things about another resident. The investigation further stated based on the investigation abuse could not be substantiated. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed his investigation of the alleged abuse

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCT A. BUILDING B. WING | TION | (X3) DATE SURVEY COMPLETED 04/09/2013 |
|---|--|--|--|--|
| CORRECTION | 185337 | | | |
| NAME OF PROVIDER OF SUI LEE COUNTY CARE & REH | | | STREET ADDRESS, CITY, STA 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | TE, ZIP |
| For information on the nursing l | nome's plan to correct this deficient | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | | ENCY MUST BE PRECEDED BY | FULL REGULATORY |
| F 0490 | interviewing LPN #1, the Charge statements describing the LPN's (oriented resident had reported wit concluded that staff might have in determine if LPN #1 had abused I disciplinary action was taken agai facility's policy revealed a thorough the concluded that staff might have in determine if LPN #1 had abused I Administrator/designee would magrievances presented to them. Fur facility's policy did not instruct st. the policy stated only the Administremoval of individuals from direct the facility's first AOC, alleging in DON, Social Worker/Abuse Coor further stated that the Chief Nurse through the present time, with no he/she had reported an allegation months prior when the incident of and the resident was afraid of the AM revealed the allegation was in provide direct care because the faconducted. There was no evidence AOC that this investigation was not Administrator #1, who was the Afacility and was not available for was also acting as the facility's A further interview on 04/05/13 at 7 he could not recall the resident's interview and review of the facility and was not available for interview and review of the facility and was not available for his provide further care for the interviewed Resident #4, the RN, Based on this information, the fac cognitive ability. Interview with thowever, did not notify the Admi Corporate Nurse Consultant quest 6:40 PM, and on 03/29/13 at 10:2 Administrator #2 stated the DON to inform him of the allegation of stated, In my heart of hearts I hav and reportable, even before the in alleging removal of jeopardy on 0 Worker/Abuse Coordinator, had the facility's abuse log revealed no 14/17/13, which alleged the remo Chief Operating Officer performe allegations of abuse, misappropriate State Agencies and he 04/17/13, which alleged the remo Chief Operating Officer performe allegations of abuse. Daily review under the resident of the following: ethe Inspector General were filed time of Immediate Jeopardy. —Based or Policy and Scale Policy and Scale Policy in the Policy in the Policy in th | Nurse. Administrator #1 acknowled Charge Nurse) intentions to teach nessing LPN #1 be inappropriate is interpreted the LPN's actions, a Resident #1. Therefore, the allegating the the LPN concerning the allege gh investigation was to be initiates, family, and/or visitors who had ike all reasonable efforts to invest ther interview with Administrator aff to immediately remove the allestrator and/or DON and/or Social of care giving or direct contact relaemoval of jeopardy on 03/06/13, indinator were re-educated beginning Executive reviewed all incidents concerns. However, during an into fabuse to the facility's Social Wectured. Resident #29 alleged that staff person. An interview with the of reported to the facility's Social Wectured. Resident #29 alleged that staff person. An interview with the of reported to the appropriate Stat cility felt it was not abuse, even the the facility identified as part of toot thorough, the abuse allegation diministrator, revealed he did recall Aciame and did not ask additional quity is investigation dated 04/01/13 rRN #8 and Resident #4 alleged RN #8 we resident and did not want RN #8 t and all residents with a Brief Inteility unsubstantiated that abuse on he DON on 04/02/13 at 845 PM inistrator, or initiate an investigation had been complete. 4. 4/05/13, revealed facility storicent. SAM, and 4:11 PM revealed he to informed him she had forgotten to abuse. Further interview revealed e gotten to know the little girl wh vestigation had been complete. 4. 14/05/13, revealed facility storicent. SAM, and 4:11 PM revealed he protect Residents #19, #29, #30, to taware of these allegations in on 04/09/13 at 5:45 PM, revealed by informed him she had forgotten to abuse. Further interview revealed existent on the protect of the seal elegations in on 04/09/13 at 5:45 PM, revealed by informed him she had forgotten to abuse allegations in the protect of the seal elegations in on 04/09/13 at 5:45 PM, revealed by interview and discuss all allegations in the ordinary of the seal elegations in the ordi | (Resident #1) a lesson and he wa and rude to another resident previous stated he was unable to come to tion of abuse was unsubstantiated ed abuse to Resident #1. However dimmediately for all alleged incident potential knowledge of the incident worker would make any immedia ted to the alleged or suspected above and investigations that occurred the arriview with Resident #29 on 04/0 forker/Abuse Coordinator approximate Agencies and the alleged perpetent by the state of the knowledge of the incident involving Ruministrator #1 telling him about the time, was no longer employed as at 6:05 PM, with the Vice Preside aware of the incident involving Ruministrator #1 telling him about the stream of the incident involving Ruministrator #1 telling him about the stream of the knowledge of the incident involving Ruministrator #1 telling him about the stream to the resident and the resident of 30/3/21/13 the Administrator was mean to the resident and the resident of the second back to Resident #4's noor second to Resident #4's noor second him the resident feel to the appropr | aff interviews and witness is aware an alert and ously. However, he had on a firm conclusion or and no further review of the lents of abuse int; the concerns, and led he was not aware the eint care. However, the decisions related to the use. 2. A review of liministrator, the earns are also as a concerns, and led he was not aware the ent care. However, the decisions related to the use. 2. A review of liministrator, the earns are also as a concerns, and led he was not aware the ent care. However, the earns are also as a concern June 2012 5/13, the resident stated mately two to three breast inappropriately tor on 04/09/13 at 11:09 rator continued to do not been as stated in the was not protected. Administrator of the not of Operations who esident #29. However, the incident; however, oncern. 3. rator was notified of ility's investigation sident did not want RN in. The facility core of 8 or higher. In the concerns are possible to the concerns and the concerns are possible to the facility to the concerns and the conceptable (AOC) on 04/11/13 and 04/12/13, the any files related to reported to end to the conceptable (AOC) on 04/11/13 and 04/12/13, the any files related to reported to end to the conceptable to the conce |

FORM CMS-2567(02-99) Every Previous Versions Obsolete

PRINTED:3/30/2014 FORM APPROVED

| | | | | OMB NO. 0938-0391 |
|--------------------------------|---|--|--|---|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUC | CTION | (X3) DATE SURVEY |
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | | COMPLETED |
| CORRECTION | NUMBER | B. WING | | 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SU | | | STREET ADDRESS, CITY, S | STATE, ZIP |
| LEE COUNTY CARE & REF | | | 246 EAST MAIN STREET | , — |
| EEE COCKTT CARE & REI | IABILITATION CENTER | | BEATTYVILLE, KY 41311 | |
| For information on the nursing | home's plan to correct this deficier | ncy, please contact the nursing ho | ome or the state survey agency. | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | | TIENCY MUST BE PRECEDED | BY FULL REGULATORY |
| F 0490 | (continued from page 45) at 12:21 PM with the Director of Rehabilitation Service Manager; Manager; at 1:16 PM with the Hthe Director of Maintenance con completed a post test. The above the remaining staff on 04/12/13. Aide (SRNA) #8; at 10:53 AM v 11:27 AM with Licensed Practic Dietary Aide #2; at 12:05 PM with SRNA #9; at 12:38 PM with SRNA #9; at 12 | Nursing; at 12:38 PM with the I at 12:57 PM with the Central Stousekeeping Manager; at 1:23 Pfirmed they had received training. Regional Staff and Department Review of post-test and interviewith Housekeeper #4; at 11:37 AM with St th SRN #7; at 12:12 PM with In SRNA #1; at 12:49 PM with C with SRNA #1; at 12:49 PM with C with SRNA #1; at 1:17 PM with Int #1 confirmed they were re-ed 3 at 2:38 PM with Administrator revealed the Independent Contragation of allegations of abuse pradt the Chief Nurse Executive at ed by the facility and no concern do assisted in completing daily re at said adily resident interviews 11:53 AM and the Regional Nursecord review and interview on 042:38 PM with the Interim Social use known and the said in the facility failed to be adminited to the facility failed to be adminited to the facility failed to be adminited and the facility failed to be adminited to the facility failed to have an effective normal said in the | ipply and Staffing Manager; at I. M with the Staff Development C g on abuse by the Independent C. Directors verified they had also ws on 04/23/13 at 10:35 AM with M with Registered Nurse #5; at 11:45 AM with Diet Registered Nurse #5; at 11:45 AM with Diet Registered Nurse #4; at 12:20 PM errified Medication Aide #1; at 1 in Maintenance Worker #1; at 1:4 ucated by Department Directors #2; at 12:21 PM with the DON; actor did provide them with one cior to 04/12/13. Interview with the total to 1:5 AM revealed, by 04/10/12 is were identified. Further interviewes, seven (7) days a week, of with no concerns identified. Intersections of the with the concent identified in the seconsultant at 11:32 AM reveal 4/23/13 at 2:38 PM with Administ Services Director revealed they noted. The Administrator stated he sure they were investigated, the exaptropriate State Agencies. Interviewing the abuse investigation ion with the revisit, an additional review of the facility's Abuse, N stered in a manner that maintaine we system in place to ensure police and Misappropriation policy, abuse along with injuries of unkity along with officials in accordation report tevealed on 04/17/12 cility's Administration that Kentur #6). According to the facility's in resident told KMA #6 that she went the report, the alleged perpetraport further revealed the allegation had be with the Chief Nurse Executive e ought not to exceed 24 hours, a recessary. The interview further revealed the allegation had be with the Chief Nurse Executive e ought not to exceed 24 hours, a recessary. The interview further revealed be not on the second and on 04/17/13. Accordad been reported to make the | 204 PM with the Dietary oordinator; and at 1:40 PM with ontractor on 04/06/13 and had assisted with education of h State Registered Nurse. 1:16 AM with Housekeeper #5; at ary Aide #1; at 11:54 AM with I with SRNA #12; at 12:28 PM 2:56 PM with Certified. 1 PM with Laundry Worker #1; an and/or Regional Staff. Record and at 12:38 PM with the on one education related to be Chief Operating 3, they had completed a review ew with the Chief led they were reviewing all strator #2; at 12:21 PM with were meeting on numerous e utilized an abuse residents were erview with the Chief log on a daily, seven (7) example of noncompliance register and with the chief log on a daily, seven (7) example of noncompliance review with State law 3, at approximately cky Medication Aide (KMA) westigation, while KMA #6 as pulling the resident's tor (KMA #6) was on was reported to the en reported to the en reported to the (CNE) revealed the evealed the CNE thought knowledged in interview on though the facility ling to the Administrator, he ort and stated he |
| F 0490 | Be administered in an acceptable Based on interview, record revie the facility failed to be administe sampled residents (Residents #1, ensure policies and procedures w Administration and to the appropacility investigations; and failed (Refer to F223, F225, F226, and prevention were developed and i residents in the facility. Immedia Immediate Jeopardy was determ Practices (F223, F225, and F226 CFR 483.13 Resident Behavior a Jeopardy on 03/01/13 and 03/29/acceptable credible Allegation of on 04/17/13. The State Survey A acceptable AOC, with remaining F225 and F226 - S/S E) and 42 C a Plan of Correction and monitor include: Review of the facility's report and thoroughly investigate reasonable suspicion of criminal reported immediately to the charwere to be notified immediately suspicion of an incident of abuse appropriate. The policy also reveabuse involving staff members, and Administrator/designee would mgrievances presented to them; an wellbeing following the incident DON and/or Social Worker wou or direct contact related to the all | w, and review of the facility's intered in a manner that maintained #4, #19, #29, #30, and #31). The week developed/implemented to evitate State Agencies; failed to entrate of the Administration of F520. The Administration of F620 and 42 CFR 483.75 Administration of Administration of Administration of Administration of F620 and F6 | vestigation and policy and proced the highest physical well-being is efacility failed to have an effect insure staff immediately reported assure all residents were protected in had been conducted related to ture to ensure facility policies/prt ly to cause, serious injury, harm, tified on 03/01/13 and 03/24/13 ongoing at 42 CFR 483.13 Residation (F490 and F520), with Subs.25, and F226). The facility was not a time to the facility alleging remost a with the facility alleging remost fithe Immediate Jeopardy on 04/13 Resident Behavior and Facilit 0 and F520 - S/S E) while the facility alleging remost called it was the intent of the facility alleging remost called it was the intent of the facility alleging remost called it was the intent of the facility allegier, abuse, misappropriation of Any report or suspicion of an inc. Director of Nursing and Abuse 6 is the report. Further review reveat to the charge nurse and/or Abuse 6 is the report. Further review reveat to the charge nurse and/or Muses to be initiated immediately for who had potential knowledge of estigate and address alleged report measures to ensure his or her in incress. The policy further stated the related to the removal of indivi | for six of twenty-nine to see system in place to allegations of abuse to allegations. If from abuse during abuse allegations, occdures related to abuse impairment, or death to related to abuse. The ent Behavior and Facility standard Quality of Care at 42 otified of the Immediate ngoing. The facility provided an ral of the Immediate Jeopardy 22-04/23/13, as alleged in the y Practices (F223 - S/S D and cility develops and implements ivities. The findings lity to immediately resident's property or ident was to be Coordinator, as appropriate, alled, Any report or e Coordinator, as all alleged incidents of the incident; the ts, concerns, and neediate safety and e Administrator and/or duals from direct care giving |

FORM CMS-2567(02-99) Previous Versions Obsolete revealed LPN #1 was immediately suspended pending the outcome of the investigation. During the facility's investigation, LPN #1 was interviewed and stated she wanted Resident #1 to stay at the nurses' station to be monitored for the resident's

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|--|--|
| DEFICIENCIES AND PLAN OF CORRECTION | // CLIA IDENNTIFICATION NUMBER | A. BUILDING B. WING | 04/09/2013 |
| | 185337 | | |
| NAME OF PROVIDER OF SUP | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| LEE COUNTY CARE & REHA | ABILITATION CENTER | 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | |
| | • | cy, please contact the nursing home or the state survey agency. | |
| | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY MATION) | 7 FULL REGULATORY |
| | (continued from page 46) behavior. Facility staff interviewe LPN say negative things about an es substantiated. Interview with Aconsisted of reviewing witness stainterviewing LPN #1, the Charge statements describing the LPN's (oriented resident had reported wit concluded that staff might have notermine if LPN #1 had abused I disciplinary action was taken agai facility's policy revealed a thorou involving staff members, resident Administrator/designee would magrievances presented to them. Fur facility's policy did not instruct st the policy stated only the Adminiremoval of individuals from direct the policy stated only the Adminiremoval of individuals from direct facility's first ACC, alleging r DON, Social Worker/Abuse Coorfurther stated that the Chief Nurschrough the present time, with no he/she had reported an allegation was n provide direct care because the faconducted. There was no evidence AOC that this investigation was not available for was also acting as the facility's A further interview on 04/05/13 at 7 he could not recall the resident's recould not notify the Administrator #1, who was the AGacility and was not available for was also acting as the facility's A further interview on 04/05/13 at 7 he could not recall the resident's recould not recall the resident's recould not recall the resident's reconstitute ability. Interview with thowever, did not notify the Admi Corporate Nurse Consultant questions of subset of the facilian allegation of abuse involving Edated 04/01/13, revealed on 03/29/13 at 10:2 Administrator #2 stated the DON to inform him of the allegation of stated, In my heart of hearts I haven and reportable, even before the in alleging removal of jeopardy on Contractor Worker/Abuse Coordinator, had residents. In addition, according to track/trend all allegations of stated, In my heart of hearts I haven allegations, Administrator #2 of failures to invest | dother residents on the unit and one other resident reported he/she other resident. The investigation further stated based on the investigation tements, information that had been obtained, consulting with his re Nurse. Administrator #1 acknowledged he had been aware of the exident #10 his possibility intentions to teach (Resident #1) a lesson and he was nessing LPM #1 be inappropriate and rude to another resident previous interpreted the LPN's actions, and stated he was unable to come textified #1. Therefore, the allegation of abuse was unsubstantiated as the LPN concerning the allegation of abuse was unsubstantiated as the LPN concerning the allegation of abuse was unsubstantiated as the LPN concerning the allegation of abuse was unsubstantiated as the investigation was to be initiated immediately for all allegad incis, family, and/or visitors who had potential knowledge of the incide all reasonable efforts to investigate and address allegat reports, their interview with Administrator #1 on 030/5/13 at 4:25 PM revealed all temperature of direct contact related to the alleged or persistrator and/or DON and/or Social Worker would make any immediate transplantial properature of the control of poperaty on 03/06/13, revealed all staff, including the Administrator of properation of properation of the properation of the properation of properation of the | gation abuse could not of the alleged abuse gional staff, and taff interviews and witness is aware an alert and tously. However, he had to a firm conclusion or, and no further reviews of the dents of abuse ent; the concerns, and aled he was not aware the ent care. However, atte decisions related to the use. 2. A review of dministrator, the abuse policy. The AOC from June 2012 15/13, the resident stated mately two to three breast inappropriately tor on 04/09/13 at 11:09 trator continued to do not been as stated in the twas not protected. Administrator of the incident; however, he incident; however, oncern. 3. trator was notified of cility's investigation esident #29. However, he incident did not want RN m. The facility score of 8 or higher. oderately impaired allegation on 03/24/13; when the on 03/28/13 at 2:00 PM, 3/27/13 around 5:40 PM. The heincident and forgot was reportable. He lit was true AOC, dated 04/05/13, ,, DON, and Social ing, and protection of Administrator to redinator on 04/09/13 in reported to facility neces, had been addition, review of and #31. An identify facility eported. Seeptable (AOC) on 04/11/13 and 04/12/13, the ray files related to ne submitted on e of the alleged abuse twestigation has been buse, completed by an e Department Directors cated upon returning to 104/13/13 to provide not review skin ignitions of interview of a statement is dallegation of a view of a statement is a view of a statement is a view of |

Facility ID: 185337

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| | | | | OMB NO. 0938-0391 |
|-----------------------------|---|---|--|--|
| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUC | TION | (X3) DATE SURVEY COMPLETED |
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | | |
| CORRECTION | NUMBER | B. WING | | 04/09/2013 |
| | 185337 | | | |
| NAME OF PROVIDER OF SU | JPPLIER | • | STREET ADDRESS, CITY, ST. | ATE, ZIP |
| LEE COUNTY CARE & RE | HABILITATION CENTER | | 246 EAST MAIN STREET | |
| | 1 1 1 | 1 | BEATTYVILLE, KY 41311 | |
| | s home's plan to correct this deficient | | | VEHI L DECHI ATODY |
| (X4) ID PREFIX TAG | OR LSC IDENTIFYING INFOR | | ENCY MUST BE PRECEDED B | I FULL REGULATOR I |
| F 0490 | (continued from page 47) Administrator #1. Interview with Nurse Executive; at 1:46 PM with 2:38 PM with Administrator #2; at 12:21 PM with the Director of Rehabilitation Service Manager; Manager; at 1:16 PM with the Hthe Director of Maintenance contoompleted a post test. The above the remaining staff on 04/12/13. Aide (SRNA) #8; at 10:53 AM will:27 AM with Licensed Practic Dietary Aide #2; at 12:05 PM with with SRNA #9; at 12:38 PM with Medication Aide #6; at 1:09 PM at 1:54 PM with Activity Assista review and interview on 04/23/1. Interim Social Services Director protection, reporting, and investi Officer on 04/23/13 at 2:12 PM at of all allegations of abuse receiv Operating Officer revealed he ha grievance reports, incident report Nurse Executive on 04/23/13 at 1 acasions daily to review any abi investigation log daily to keep tra protected, and that the allegation Nurse Executive on 04/22/13 at 2 days a week, basisDuring a complaint investigati was identified. Interview, review Misappropriation Policy, reveale well-being for Resident #32. The were developed/implemented to (Refer to F225 and F226.) A rev (effective April 2013, revealed, al immediately to the charge nurse through established guidelines. A 10:50 AM, Licensed Practical N #6 reported an allegation that hax was providing care to Resident # hair and trying to kill the residen immediately suspended and an in State Survey Agency on 04/18/1: administration of the facility on the time frame was in business h 04/22/13 at 1:58 PM that the faci staff had reported the incident to thought the facility had until mid | on 04/23/13 at 11:32 AM with the het Clinical Regional Nurse Coat 10:35 AM with the Director of Nursing: at 12:38 PM with the In at 12:57 PM with the Central Supousekeeping Manager; at 1:23 PM firmed they had received training Regional Staff and Department I Review of post-test and interview with Housekeeper #4; at 11:37 AM with SI the SRNA #1; at 12:12 PM with Ris SRNA #1; at 12:12 PM with SRNA #1; at 12:12 PM with Ce with SRNA #1; at 12:12 PM with Coat with SRNA #1; at 12:14 PM with Int #1 confirmed they were re-edu 3 at 2:38 PM with Administrator revealed the Independent Contract gation of allegations of abuse pricand the Chief Nurse Executive at edby the facility and no concerns do assisted in completing daily revites, and daily resident interviews with: 53 AM and the Regional Nurse cord review and interview on 04/2:38 PM with the Interim Social Suse investigations that were report ask of all abuse allegations to ensish ad been reported timely to the 2:15 PM revealed she assists in revent of the facility failed to be administ a facility failed to be administ and the facility failed to be administ and the facility investigation and review of the facility Sabuse, Negled allegations of abuse were the wor of the facility investigation and review of the facility investigation and review of the facility investigation was initiated. The rep 3 at 5:52 PM (a timeframe of 31 heterview on 04/22/13 at 2:15 PM veporting of an allegation of abuse uld have more time to report if ne ours and the facility was a 24-hou lity had not reported the incident Administration at approximately hight the day after an incident had | ne Regional Nurse Consultant; at Insultant; at 2:12 PM with the Chie Admissions; at 12:09 PM with the Chie Admissions; at 12:09 PM with the terrim Social Services Director; at oply and Staffing Manager; at 1:04 With the Staff Development Coorn abuse by the Independent Condirectors verified they had also assess on 04/23/13 at 10:35 AM with Significant of With Registered Nurse #5; at 11:8NA #5; at 11:45 AM with Dietary egistered Nurse #4; at 12:20 PM with Grade Medication Aide #1; at 12: Maintenance Worker #1; at 1:41 Fox at 12:21 PM with the DON; and the staff of the provide them with one on or to 04/12/13. Interview with the 11:53 AM revealed, by 04/10/13, were identified. Further interview itews, seven (7) days a week, of at with no concerns identified. Interview Consultant at 11:32 AM revealed 23/13 at 2:38 PM with Administrators Consultant at 11:32 AM revealed they we ted. The Administrator stated he ure they were investigated, the resappropriate State Agencies. Interviewing the abuse investigation loon with the revisit, an additional exercise of the facility's Abuse, Negtered in a manner that maintained experience of the State Survey Agenct and Misappropriation policy, rebuse along with officials in accordanction report revealed on 04/17/13, ality's Administration that Kentuck 6). According to the facility's investigation to the Knate Survey Agenct and Misappropriation policy, rebuse along with officials in accordanction report revealed on 04/17/13, ality's Administration that Kentuck 6). According to the facility's investigation to the Chief Nurse Executive (Clought not to exceed 24 hours, and cessary. The interview further rever business. Administrator #2 acknuril 04/18/13 at 5:52 PM even the 10:50 AM on 04/17/13. Accordin deen reported to midnight the chief of the make the report incident occurred to midnight the chief of the make the report incident occurred to midnight the chief of the make the report incident occurred to midnight the chief of the make the report incident occurred to midnight the chief | of Operating Officer; at equality of Life Director; 12:45 PM with the PM with the Detary rdinator; and at 1:40 PM with ractor on 04/06/13 and had isted with education of tate Registered Nurse 16 AM with Housekeeper #5; at 7 Aide #1; at 11:54 AM with with SRNA #12; at 12:28 PM 56 PM with Certified M with Laundry Worker #1; and d/or Regional Staff. Record dat 12:38 PM with the one education related to Chief Operating hey had completed a review with the Chief ouse allegations, ew with the Chief they were reviewing all stor #2; at 12:21 PM with re meeting on numerous tilized an abuse idents were iew with the Chief go on a daily, seven (7) cample of noncompliance leet and the highest physical is and procedures by in a timely manner. Aid with State law at approximately y Medication Aide (KMA) stigation, while KMA #6 pulling the resident's (KMA #6) was was reported to the reported to the reported to the reported to the lacility go to the Administrator, he and stated he |
| F 0514 | professional standards. **NOTE- TERMS IN BRACKE' Based on interview and record re accepted professional standards a residents (Residents #4, #29, #30 abuse to the facility; however, the resident's medical record. The fir revealed it was the policy of the of a false claim was to falsify inf allegation dated 03/27/13, signed (DON) encouraged the Registere record. A review of Resident #4's on 03/23/13 at 12:30 AM reveale Stating to Res to use call light at your mouth. You don't have any and leave me alone. This nurse s prevent falling, will continue to to Answering Res call light at this t assisted to bathroom. Res appear continue to mx, and was also sig the DON was interviewing RN # he heard a comment about doing RN #8 take the nurse's notes out nurse's note. Administrator #2 st stated to the Administrator #2 st stated to the Administrator that s Administrator #2 stated the DON the record, and RN #8 rewrote th the rewriting of the nurse's note; what she was doing. Interview w she explained to the RN she need she had RN #8 to write it down c stated she pulled the original nur Administrator #2 stated to the DO | eview, the facility failed to ensure and practices and contained accurry, and #31). Interviews revealed R ere was no evidence the facility hadings include: 1. A review of the company to be committed to its reformation in the medical record. A by Administrator #2 revealed du d Nurse (RN) to rewrite a note and smedical record on 03/28/13 reved, Answering Res alarm sounding beside to ring for staff assistance right to quarrel at me. Your mout stating to Res will remain in room mx Res, and was signed by Registime. Res states she needs to urina sagitated, continues to get up witned by RN #8. Interview with Ad 8 related to the abuse allegation. I late notes. Administrator #2 state of Resident #4's medical record reated he asked the DON, Is that no ince that was the only note on the said the nurse's note was not part in the DON on 04/02/13 at 8:45 led to document Resident #4's bed on a new nurse's note since the orise's note out of the chart and aske ON that he would shred it, so the low | ROTECT CONFIDENTIALITY** clinical records were maintained at a documentation for four of twe residents #4, #29, #30, and #31 regard documented any of the allegation of the allegation of the preventing health care fraud a documented any of the allegation of the allegation of the preventing health care fraud a review of an initial investigation ring the investigation it appears the dreplace the original note in the realed nurse's notes dated 03/23/13, gin room, Res noted on toilet in but with ambulation to bathroom. Resh is going just like a duck's mouth and assist to ambulate back to be tered Nurse (RN) #8. A second note at this time. Res assisted to sit thout assistance, refuses to use calministrator #2 on 03/28/13 at 6:40 Administrator #2 stated he was had the then came to the conclusion regarding the alleged abuse on 03/2 to part of the record? Further interview page the nurse could write a clarit of the medical record, and then re interview revealed Administrator #2 stated he what to ginal note only had one entry writed Administrator #2 what to do wit DON stated she tore it up. The DC sick to my stomach. Interview we | n accordance with nty-nine sampled borted allegations of ons/reports in the dated 01/01/08, and abuse. An example of an abuse e Director of Nursing esident's medical. A nurse's note written athroom at this time. states 'you shut . Now you just shut up d when finished to te at 3:30 AM revealed, up in bed. Res light. Will PM revealed on 03/27/13, If paying attention when the DON was going to have 'A/13 and rewrite the iew revealed the DON fication note. emoved the note from or #2 did not agree with s so he assumed she knew with RN #8 on 03/27/13 that document. The DON the original note. NY further stated she |
| | | | e sick to my stomach. Interview wo | |

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 48 of 59

PRINTED:3/30/2014

| CENTERS FOR MEDICARI | E & MEDICAID SERVICES | | FORM APPROVED OMB NO. 0938-0391 |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF S LEE COUNTY CARE & RI | | STREET ADDRESS, (246 EAST MAIN STR BEATTYVILLE, KY | REET |
| For information on the nursin (X4) ID PREFIX TAG | g home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY | | |
| F 0514 | (continued from page 48) didn't have to put everything that transpired in the nurse's notes. According to RN #8, the DON had her to rewrite the nurse's note dated 03/24/13 in Resident #4's medical record to indicate the resident was well through the shift with no further behaviors. RN #8 stated she completed the documentation but was not aware the original nurse's note was going to be removed from Resident #4's medical record. On 03/29/13, Administrator #2 provided the nurse's note was going to be removed from Resident #4's medical record. On 03/29/13, Administrator #2 provided the nurse's note was going to be removed from Resident #4's medical record, which according to the DON had been torn up. Review of the nurse's note as 3:30 AM revealed. Answering Res call light at this time. Resident states she needs to urnate at this time. Res assisted to sit up in bed. Res stating Honey, what's your name?' This nurse stating name. Res stating 'I think I've seen you before. Do I know you?' This nurse stating yes, Res states 'Honey, I hate to say this, but you were mean to me last night. Res continuing to state 'I have to pee,' assisted to bathroom and assisted to ambulate back to bed. Res stating 'Honey, I don't want you to come in my room anymore. We just can't get along. I'm going to pee without anybody!' Res encouraged to use call light for assistance with ambulation to bathroom, assured CNA would assist with ambulation if Res no longer wished for this nurse to do so. Will continue to mx. The note was signed by RN #8, 2. Interview conducted with Administrator #2 on 04/09/13 at 6:15 PM, revealed the facility did not have a pobley that addressed what was required to be documented in the medical record. In an interview conducted with Resident #29 stated he/she reported this incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, confirmed Resident #29 reported to that SRN# #14 touched the resident's breast on 03/01/13. According to the So | | Il through the shift with no iginal nurse's note was going to be unrse's note that had been removed of the nurse's notes at 3:30 AM ime. Res assisted to sit up to the street of the nurse's notes at 3:30 AM ime. Res assisted to sit up to respect to me last night.' Res d. Res stating 'Honey, I don't unybody!' Res encouraged to use call on if Res no longer wished for this d with Administrator #2 on 04/09/13 be documented in the medical stated he/she was afraid of State resident's breast while hugging the ocial Worker/Abuse Coordinator. Confirmed Resident #29 reported to her 'Abuse Coordinator, she was not sure any resident concern should be mented the allegation in the medical onfirmed the Social Worker/Abuse all Worker/Abuse Coordinator on d on 03/24/13 Resident #30 and had wrapped a sheet around the rever, a review of the medical idence of documentation of the land did not contain any 4/08/13, 4. Interview with about an allegation reported on won in a chair too hard by facility he medical record for Resident to 04/09/13, revealed facility d during the timeframe noted. 11:09 AM, revealed the Social abuse in the Social Services Progress :45 PM revealed he was not familiar all Worker/Abuse Coordinator |
| F 0514 | Keep accurate, complete and organized clinical records on each resident that meet professional standards. **NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices and contained accurate documentation for four of twenty-nine sampled residents (Residents #4, #29, #30, and #31). Interviews revealed Residents #4, #29, #30, and #31 reported allegations of abuse to the facility; however, there was no evidence the facility had documented any of the allegations of abuse to the facility; however, there was no evidence the facility had documented any of the allegations of abuse to the facility information in the medical record. A review of an initial investigation of an abuse and a false claim was to falsify information in the medical record. A review of an initial investigation of an abuse and a false claim was to falsify information in the medical record. A review of an initial investigation of an abuse and a false claim was to falsify information in the medical record. A review of Resident #4s medical record on 0.32/81/3 revealed unres' notes atted 0.32/31/3. A nurse's note writt on 0.32/31/3 at 12:30 AM revealed. Answering Res alarm sounding in room, Res noted on toilet in bathroom at this time. Stating to Res to use call light at beside to ring for staff assistance with ambulation to bathroom. Res stay you shut your mouth. You don't have any right to quarrel at me. Your mouth is going just like a duck's mouth. Now you just shut and leave me alone. This invest stating to Res will remain in room and assist to ambulate back to bed when finished to prevent falling, will continue to mx Res, and was signed by Registered Nurse (RN) #8. A second note at 3:30 AM rever Answering Res call light at this time. Res sattes she needs to urnate at this time. Res assisted to be the nurse's note with the Don's many and the province of the prevent falling w | | aintained in accordance with ur of twenty-nine sampled and #31 reported allegations of the allegations/reports in the aims Act, dated 01/01/08, are fraud and abuse. An example estigation of an abuse appears the Director of Nursing tee in the resident's medical 03/23/13. A nurse's note written toilet in bathroom at this time. room. Res states 'you shut k's mouth. Now you just shut up ack to bed when finished to the total to be the total to be the total to be to be the total to be to be the total to be to b |

Event ID: YL1O11 FORM CMS-2567(02-99) Facility ID: 185337 If continuation sheet Page 49 of 59

DDINTED:3/30/2014

| | EE & MEDICAID SERVICES | | FORM APPROVED OMB NO. 0938-0391 |
|---|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF | SUPPLIER | | SS, CITY, STATE, ZIP |
| LEE COUNTY CARE & R | EHABILITATION CENTER | 246 EAST MAIN BEATTYVILLE, | |
| For information on the nursi (X4) ID PREFIX TAG | | cy, please contact the nursing home or the state surve DEFICIENCIES (EACH DEFICIENCY MUST BE P. | |
| | OR LSC IDENTIFYING INFOR! | | RECEDED BY FOLE RECOEMFORT |
| F 0514 | Registered Nurse Aide (SRNA) # resident two to three months ago. Interview conducted with the Soc that SRNA #14 touched the residif allegations of abuse should be documented in the record. The Sc record for Resident #29. Review Coordinator had failed to docume 03/01/13 in Resident #29's medic alleged that SRNA #13 had repearesident's neck too tight following record, including nurse's notes an allegation made by Resident #30 documentation related to the incit Administrator #2 at 5:00 PM rev 04/08/13 by the Social Worker/A staff. The incident reportedly occ #31, including nurse's notes and \$ staff failed to document detailed in the trip and the worker/Abuse Coordinator had notes regarding Resident #31. Int with the facility's documentation | with Resident #29 on 04/05/13, at 5:50 PM, the resident A. The resident further reported SRNA #14 touched Resident #29 stated he/she reported this incident to tail Worker/Abuse Coordinator on 04/05/13, at 6:50 Fent's breast on 03/01/13. According to the Social Worlocumented in the resident's medical record, but belie ocial Worker/Abuse Coordinator stated she had not do for the Social Worker/Abuse Coordinator progress not the alleged incident that had been reported to the Sal record. 3. A review of a facility's investigation revitedly sprayed cold water on the resident during a shog the shower on 03/22/13 from 8:00 PM to 9:00 PM. d Social Services Notes for Resident #30, revealed not facility staff on 03/22/13, the day the incident occulent after the facility became aware of the allegation caled Administrator #2 had talked with staff on 04/09 buse Coordinator that Resident #31 may have been surred during the timeframe of 03/17-19/13. A review social Services Progress Notes for the period of 03/01 information related to the allegation of abuse that occ facility Social Worker/Abuse Coordinator on 04/09/13 policies. Administrator #2 stated he would think the ged incidents in the Social Services Progress Notes in each of the seed incidents in the Social Services Progress Notes in the seed incidents in the Social Services Progress Notes in the seed incidents in the Social Services Progress Notes in the seed incidents in the Social Services Progress Notes in | the resident's breast while hugging the the Social Worker/Abuse Coordinator. PM confirmed Resident #29 reported to her rker/Abuse Coordinator, she was not sure eved any resident concern should be ocumented the allegation in the medical tes confirmed the Social Worker/Abuse Social Worker/Abuse Coordinator on ealed on 03/24/13 Resident #30 ower and had wrapped a sheet around the However, a review of the medical o evidence of documentation of the turred, and did not contain any on 04/08/13. 4. Interview with 1/13 about an allegation reported on et down in a chair too hard by facility of the medical record for Resident 1/13 to 04/09/13, revealed facility curred during the timeframe noted. If all 1:09 AM, revealed the Social so f abuse in the Social Services Progress at 5:45 PM revealed he was not familiar Social Worker/Abuse Coordinator |
| F 0514 | professional standards. **NOTE- TERMS IN BRACKET Based on interview and record re accepted professional standards a residents (Residents #4, #29, #30 abuse to the facility; however, the resident's medical record. The fin revealed it was the policy of the c of a false claim was to falsify infe allegation dated 03/27/13, signed (DON) encouraged the Registere record. A review of Resident #4's on 03/23/13 at 12:30 AM reveale Stating to Res to use call light at 1 your mouth. You don't have any I and leave me alone.' This nurse st prevent falling, will continue to n Answering Res call light at this ti assisted to bathroom. Res appears continue to mx, and was also sign the DON was interviewing RN #h he heard a comment about doing RN #8 take the nurse's notes out o nurse's note. Administrator #2 sta stated to the Administrator that si Administrator #2 stated the DON the record, and RN #8 rewrote th the rewriting of the nurse's note; what she was doing. Interview wi she explained to the RN she need she had RN #8 to write it down o stated she pulled the original nurs Administrator #2 stated to the DC knew it was wrong to tear up the 8:07 PM revealed when she was i didn't have to put everything that nurse's note dated 03/24/13 in Re further behaviors. RN #8 stated sl removed from Resident #4's medical recor revealed, Answering Res call ligh in bed. Res stating 'Honey, what's know you?' This nurse stating yee want you to come in my room an light for assistance with ambulant urse to do so. Will continue to n at 6:15 PM, revealed the facility o record. In an interview conducted Registered Nurse Aide (SRNA) # resident two to three months ago. Interview conducted with the Soc that SRNA #14 touched the resid if allegations of abuse should be o documented in the record. The Sc record for Resident #29's medic alleged that SRNA #13 had repea resident's neck too tight following | ganized clinical records on each resident that meets? HAVE BEEN EDITED TO PROTECT CONFIDE view, the facility failed to ensure clinical records wern dipractices and contained accurate documentation for an an an an according to the facility failed to ensure clinical records wern dipractices and contained accurate documentation for an according to the facility had documented any dings include: 1. A review of the facility policy, Fals ompany to be committed to its role in preventing hearmation in the medical record. A review of an initial by Administrator #2 revealed during the investigation of Nurse (RN) to rewrite a note and replace the original medical record on 03/28/13 revealed nurse's notes of d., Answering Res alarm sounding in room, Res note oeside to ring for staff assistance with ambulation to light to quarrel at me. Your mouth is going just like a ating to Res will remain in room and assist to ambulax Res, and was signed by Registered Nurse (RN) #8 me. Res states she needs to urinate at this time. Res a agitated, continues to get up without assistance, refued by RN #8. Interview with Administrator #2 on 03 related to the abuse allegation. Administrator #2 at late notes. Administrator #2 state the network of Resident #4's medical record regarding the alleged ted he asked the DON, Is that not part of the record? nee that was the only note on the page the nurse couls said the nurse's note was not part of the medical record regarding the alleged to document Resident #4's noncompliance, and to no a new nurse's note since the original note only had e's note out of the chart and asked Administrator #2 to Not that he would shred it, so the DON regarding the altranspired in the nurse's notes. According to RN #8, sident #4's medical record to indicate the resident was note out of the chart and asked Administrator #2 to Not that he would shred it, so the DON regarding the altranspired in the nurse's notes. According to RN #8, sident #4's medical record, On 03/29/13, Administrator #2 powers with the sident #29 on 04 | emaintained in accordance with or four of twenty-nine sampled 10, and #31 reported allegations of of the allegations/reports in the recordance with or four of twenty-nine sampled 10, and #31 reported allegations of of the allegations/reports in the recordance with the recordance with the recordance of the allegation of an abuse. An example Linvestigation of an abuse an it appears the Director of Nursing al note in the resident's medical ated 03/23/13. A nurse's note written dontoilet in bathroom at this time. Bathroom. Res states 'you shut the duck's mouth. Now you just shut up ate back to bed when finished to a current of the recordance of the recorda |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 50 of 59

PRINTED:3/30/2014

| CENTERS FOR MEDICARE | & MEDICAID SERVICES | | FORM APPROVED OMB NO. 0938-0391 |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| NAME OF PROVIDER OF SU | 185337 PPLIER | STREET AD | DRESS, CITY, STATE, ZIP |
| LEE COUNTY CARE & REHABILITATION CENTER | | 246 EAST M | IAIN STREET LLE, KY 41311 |
| | 1 . | cy, please contact the nursing home or the state | |
| (X4) ID PREFIX TAG | OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIENCY MUST MATION) | BE PRECEDED BY FULL REGULATOR (|
| F 0514 | documentation related to the inci- Administrator #2 at 5:00 PM rev 04/08/13 by the Social Worker/A staff. The incident reportedly occ #31, including nurse's notes and \$\$ staff failed to document detailed. An interview conducted with the Worker/Abuse Coordinator had in notes regarding Resident #31. Int with the facility's documentation | to facility staff on 03/22/13, the day the incident after the facility became aware of the allegealed Administrator #2 had talked with staff on buse Coordinator that Resident #31 may have burred during the timeframe of 03/17-19/13. A resocial Services Progress Notes for the period of information related to the allegation of abuse the facility Social Worker/Abuse Coordinator on 00 to documented any information regarding allegerview conducted with Administrator #2 on 04/policies. Administrator #2 stated he would thinliged incidents in the Social Services Progress No. | ation on 04/08/13. 4. Interview with 04/09/13 about an allegation reported on osen set down in a chair too hard by facility eview of the medical record for Resident 03/01/13 to 04/09/13, revealed facility at occurred during the timeframe noted. 4/09/13 at 11:09 AM, revealed the Social ations of abuse in the Social Services Progress 09/13 at 5:45 PM revealed he was not familiar k the Social Worker/Abuse Coordinator |
| F 0514 | professional standards. ***NOTE-TERMS IN BRACKET Based on interview and record re accepted professional standards a residents (Residents #4, #29, #30 abuse to the facility; however, the resident's medical record. The fin revealed it was the policy of the co of a false claim was to falsify infa allegation dated 03/27/13, signed (DON) encouraged the Registere record. A review of Resident #4's on 03/23/13 at 12:30 AM reveale Stating to Res to use call light at your mouth. You don't have any and leave me alone. This nurse si prevent falling, will continue to n Answering Res call light at this ti assisted to bathroom. Res appear continue to mx, and was also sign the DON was interviewing RN #8 he heard a comment about doing RN #8 take the nurse's notes out nurse's note. Administrator #2 stated to the Administrator #2 stated to the Administrator #2 stated to the Administrator that si Administrator #2 stated the DON the record, and RN #8 rewrote the the rewriting of the nurse's note; what she was doing. Interview w she explaimed to the RN she need she had RN #8 to write it down o stated she pulled the original nurs Administrator #2 stated to the DC knew it was wrong to tear up the 8:07 PM revealed when she was didn't have to put everything that nurse's note dated 03/24/13 in Re further behaviors. RN #8 stated's removed from Resident #4's med from Resident #4's medical recor revealed, Answering Res call ligh in bed. Res stating 'Honey, what's know you?' This nurse stating ye; continuing to state 'I have to pee, want you to come in my room an light for assistance with ambulati nurse to do so. Will continue to n at 6:15 PM, revealed the facility's record. In an interview conducted condition and by Resident #4's resident two to three months ago. Interview conducted with the Soo that SRNA #14 touched the resid if allegations of abuse should be documented in the record. The Sc record for Resident #29's medic alleged that SRNA #13 had repea resident's neck too tight following record, including nurse's notes and staff failed t | of Resident #4's medical record regarding the al ted he asked the DON, Is that not part of the rece that was the only note on the page the nurse said the nurse's note was not part of the medical enurse's note for 03/24/13. Further interview reconserver, the stated the DON has been a nurse four the DON on 04/02/13 at 8:45 PM revealed ded to document Resident #4's noncompliance, and a new nurse's note since the original note only se's note out of the chart and asked Administrate DN that he would shred it, so the DON stated shortiginal nurse's notes, it made me sick to my strength of the theorem of the | Is were maintained in accordance with tion for four of twenty-nine sampled 29, #30, and #31 reported allegations of d any of the allegations/reports in the 4, False Claims Act, dated 01/01/08, ghealth care fraud and abuse. An example initial investigation of an abuse igation it appears the Director of Nursing original note in the resident's medical tostes dated 03/23/13. A nurse's note written anoted on toilet in bathroom at this time. On the bathroom. Res states 'you shut like a duck's mouth. Now you just shut up in the back to be when finished to the same of the property of the pro |

FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 51 of 59 Event ID: YL1O11 Facility ID: 185337

Train all employees on what to do in an emergency, and carry out announced staff drills.

F 0518

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION F 0518 Based on interview and record review it was determined the facility failed to ensure emergency fire procedures were periodically reviewed with one of three existing staff members. A Laundry Aide was not knowledgeable regarding the procedures to implement in the event there was a fire in the Laundry. The findings include: A review of the facility's Fire Safety Procedure Plan, dated January 2005, revealed if a fire was discovered in the laundry area staff was to pull the nearest fire alarm and fight the fire with a portable fire extinguisher. An interview conducted on 04/03/13 at 10:15 AM, with a Laundry Aide who had been assigned to the Laundry on 04/03/13, revealed the Laundry Aide was not aware of the procedure to take in the event of a fire in the laundry area. The Laundry Aide stated that even though she had participated in a fire drill on the C Wing of the facility, she had not participated in a fire drill in the laundry area. According to the Laundry Aide, during the fire drill on the C Wing, another housekeeping staff person instructed her on what to do during the fire drill because the facility had not trained her on the procedures to take in the event of a fire at the facility. A review of the facility's employee training for fire safety revealed a post test had been completed by the Laundry Aide on 06/26/12 that revealed the Laundry Aide had been trained regarding the facility's general fire procedures; however, it could not be determined that the training included the laundry area. An interview with the Housekeeping/Laundry Supervisor on 04/03/13 at 5:15 PM revealed the Supervisor was not aware the Laundry Aide was not knowledgeable regarding fire procedures for the laundry area. In addition, the Housekeeping/Laundry Supervisor stated she was not aware of any fire drills that had been conducted in the laundry area for Laundry Room staff. An interview conducted with the Maintenance Director on 04/03/13 at 5:30 PM, revealed the Maintenance Director had not conducted any fire drills in the laundry area for the Laundry Aide. F 0518 Train all employees on what to do in an emergency, and carry out announced staff drills, Based on interview and record review it was determined the facility failed to ensure emergency fire procedures were Based on interview and record review it was determined the facility failed to ensure emergency fire procedures were periodically reviewed with one of three existing staff members. A Laundry Aide was not knowledgeable regarding the procedures to implement in the event there was a fire in the Laundry. The findings include: A review of the facility's Fire Safety Procedure Plan, dated January 2005, revealed if a fire was discovered in the laundry area staff was to pull the nearest fire alarm and fight the fire with a portable fire extinguisher. An interview conducted on 04/03/13 at 10:15 AM, with a Laundry Aide who had been assigned to the Laundry on 04/03/13, revealed the Laundry Aide was not aware of the procedure to take in the event of a fire in the laundry area. The Laundry Aide stated that even though she had participated in a fire drill on the C Wing of the facility, she had not participated in a fire drill in the laundry area. According to the Laundry Aide, during the fire drill on the C Wing, another housekeeping staff person instructed her on what to do the launder of the laundry had been the control of the laundry area. during the fire drill because the facility had not trained her on the procedures to take in the event of a fire at the facility. A review of the facility's employee training for fire safety revealed a post test had been completed by the Laundry Aide on 06/26/12 that revealed the Laundry Aide had been trained regarding the facility's general fire procedures; however, it could not be determined that the training included the laundry area. An interview with the Housekeeping/Laundry Supervisor on 04/03/13 at 5:15 PM revealed the Supervisor was not aware the Laundry Aide was not knowledgeable regarding fire procedures for the laundry area. In addition, the Housekeeping/Laundry Supervisor stated she was not aware of any fire drills that had been conducted in the laundry area for Laundry Room staff. An interview conducted with the Maintenance Director on 04/03/13 at 5:30 PM, revealed the Maintenance Director had not conducted any fire drills in the laundry area for the Laundry Aide. F 0520 Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action. Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.

Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility. Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31, luterview and record review revealed administrative staff failed to throughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. Refer to 12-23, F225, F226, and F490.) The facility failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm. imparment, or death to residents in the facility. I'vo Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy on determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable deroilbe Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/12-2-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 residents behavior and Facility restrice identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition, on 04/05/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility had reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Previous Versions Obsolete Page 52 of 59

log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY F 0520 plans of action were effective in identifying allegations of abuse and ensuring all allegations were reported/investigated and residents were protected. On 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In and residents were protected. On 03/29/15, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In addition, an interview with Administrator #2 revealed the abuse log was not effective to tientify facility falliures to report and investigate allegations of abuse and to protect Residents #19, #29, #30, and #31. Per interview, Administrator #2 was not aware of these allegations of abuse. An interview on 04/09/13 at 11:09 AM with the Social Worker/Abuse Coordinator, who was a member of the monthly QA committee and as of 04/08/13 was no longer employed by the facility, revealed she did not have a way to track or a log to review any complaints or allegations related to abuse. She further stated there was no way of knowing what allegations have been made and she was not awore of who was supposed to review these allegations. Further interview revealed she gave any paperwork she had related to the allegations to the Administrator An interview with Administrator 2 on 04/09/13 at 11:40 AM revealed that or for to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been protected. The Administrator stated to ke different abuse had not been reported/investigated and residents had not been reported/investigated and residents had not been protected. The Administrator stated to took a different set of eyes is all I can say to identify the allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) will visit 20 residents daily with a BIMS score of less than 7 and will speak to the Nurse and CNA (State Registered Nurse Aide) regarding any noted changes to the resident's behavior. In addition, a licensed nurse will complete a head to toe skin assessment for the 20 residents with BIMS score of less than 7, to ensure that no physical signs of abuse are present. The above interviews and skin audits will be placed in a binder called the AOC binder that will be located in the Administrator's office. Findings of signs and will be placed in a binder called the AQC binder that will be located in the Administrators office. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Administrator, Director of Nursing, Social Services Director, or Regional Staff will review all resident and staff questionnaires daily for grievances/concerns. Investigations of grievances/concerns will be initiated upon identification. All resident records were reviewed by the Clinical Regional Nurse Consultant on 04/12/13 for documentation proceedings there are the process of the policy process of the policy process. for documentation regarding abuse, with no new incidents being identified. Ten resident records are being reviewed by Administrative Nurses (Director of Nursing, Staff Development Coordinator, MDS Coordinators, Unit Manager, Assistant Director of Nursing) or Regional Nurse Consultants (Regional Nurse Consultants, Director of Clinical Programs, Chief Nurse Executive) daily to ensure that no other abuse allegations have been documented without reporting. This will continue until the removal of Immediate Jeopardy. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ——Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:04 PM with the Director of Admissions; at 12:04 PM with the Staff Development Coordinator; at 11:32

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 53)
Interview on 04/23/13 at 10:35 AM with SRNA #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:25 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #1; at 12:49 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:38 PM with SRNA #1; at 12:49 PM with Grutified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 revealed management staff had spoken with floor staff daily regarding their knowledge of the facility's policy on abuse and if they were aware of any potential abuse situations in the facility. Interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they had met daily, seven days a week, and had reviewed all resident and staff questionnaires that had been conducted to identify any concerns. No concerns had been identified. Record review and interview on 04/23/13 at 1:46 PM with the Clinical Regional Nurse Consultant revealed she had conducted chart audits on 100% of the charts in the facility in an effort to identify potential abuse, which may have been documented but not reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 F 0520 reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurse Consultant revealed they were conducting ten (10) chart audits a day, seven days a week, to review for signs of abuse that were reported and no concerns were identified. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action. F 0520 Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31. Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F223, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Two Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/2-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure entitled Quality Assurance/Continuous Quality Improvement, with no date, revealed systems should be in place so that problems were prevented from ever occurring. Further review of the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1 the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1. To provide a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and effective systems of services and positive care measures rendered, reinforced, and expanded to improve care given. 2. To establish and provide a system whereby a specific process and the documentation relative to it was maintained to support evidence of an ongoing quality assurance/continuous improvement plan, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to nursing home residents. 3. To develop monitoring tools that provide an effective mechanism to assure that each resident received the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 4. To assist facilities that provided care to residents to delineate lines of authority, responsibility, and accountability so that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility. The policy further stated all corrective activities would be monitored to determine appropriateness and/or the need for alternative measures. According to the policy/procedure, the Administrator of the facility was ultimately responsible for the quality assurance/continuous improvement program and was also responsible for ensuring the quality assurance/continuous improvement program of the facility was in compliance with federal, state, and local regulatory requirements. Based on interview and record review Immediate Jeopardy was identified on 03/01/13 and on 03/29/13 because of the facility's failure to identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition, on 04/06/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility was reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation log was to be mai

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337
Previous Versions Obsolete

PRINTED:3/30/2014 FORM APPROVED

| | | | OMB NO. 0938-0391 |
|------------------------------|---|--|---|
| DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/09/2013 |
| | 185337 | | |
| NAME OF PROVIDER OF SUPPLIER | | STREET ADDRESS, CITY, STA | ATE, ZIP |

246 EAST MAIN STREET BEATTYVILLE, KY 41311 LEE COUNTY CARE & REHABILITATION CENTER

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG

F 0520

Administrator. An interview with Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been abuse alregations and the was tool that all aduse alregations had been reported. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse had not been reported/investigated and residents had not been protected. The Administrator stated it took a different set of eyes is all I can say to identify the allegations. The Administrator further stated he did not feel staff was properly trained on how to identify abuse allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as part of the facility's AOCs had not been reviewed through the facility's QA program.—The facility provided an acceptable AOC on 04/17/13, which alleged removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. Administrator #1, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neelect, or misappropriation. Findings of signs and symptoms of potential abuse daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Adult Director, Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) will visit 20 residents daily with a BIMS score of less than 7 and will speak to the Nurse and CNA (Stafe Registered Nurse Aide) regarding any noted changes to the resident's behavior. In addition, a licensed nurse will complete a head to toe skin assessment for the 20 residents with BIMS score of less than 7, to ensure that no physical signs of abuse are present. The above interviews and skin audits will be placed in a binder called the AOC binder that will be located in the Administrator's office. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Administrator, Director of Nursing, Social Services Director, or Regional Staff will review all resident and staff questionnaires daily for grievances/concerns. Investigations of grievances/concerns will be initiated upon identification. All resident records were reviewed by the Clinical Regional Nurse Consultant on 04/12/13 for documentation regarding abuse, with no new incidents being identified. Ten resident records are being reviewed by Administrative Nurses (Director of Nursing, Staff Development Coordinator, MDS Coordinators, Unit Manager, Assistant Director of Nursing) or Regional Nurse Consultants (Regional Nurse Consultants, Director of Clinical Programs, Chief Nurse Director of Nursing) or Regional Nurse Consultants (Regional Nurse Consultants, Director of Clinical Programs, Chief Nur Executive) daily to ensure that no other abuse allegations have been documented without reporting. This will continue until the removal of Immediate Jeopardy. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected the negretardor is removed from resident care area reports. investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. —Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting twenty (20) interviews daily, seven (7) days a week, of residents with a BIMS of seven (7) or higher related to abuse/neglect. Further interviews and record review revealed the staff had also visited with twenty (20) residents a day, seven (7) days a week, who had a BIMS below seven (7), and had spoken to the Nurse and SRNA regarding any changes in behaviors or signs of abuse. Record review and interview on 04/23/13 at 1:23 PM with the Staff Development Coordinator; at 11:32 AM with the Regional Nurse Consultant; at 11:53 with the Chief Nurse Executive; and at 12:21 PM with the Director of Nursing revealed they had assisted with conducting twenty (20) skin assessm Executive; and at 12:21 PM with the Director of Nursing revealed they had assisted with conducting twenty (20) skin assessments a day, seven (7) days a week, of the residents that were non-interviewable and had not identified any concerns related to physical abuse. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:48 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting interviews with twenty (20) staff PM with the Staff Development Coordinator revealed they had assisted with conducting interviews with twenty (20) staff members a day, seven (7) days a week, regarding their knowledge of the facility's policy on abuse/potential abuse. Interview on 04/23/13 at 10:35 AM with SRNA #8; at 10:53 AM with Housekeeper #4; at 11:37 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #2; at 12:20 PM with SRNA #1; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #12; at 12:28 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:50 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 revealed management staff had spoken with floor staff daily regarding their knowledge of the facility's policy on abuse and if they were aware of any potential abuse situations in the facility. Interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director revealed thank group and had reviewed all resident and with the Intervine Social Services Director revealed they had met daily seven days a week and had reviewed all resident and with the Interim Social Services Director revealed they had met daily, seven days a week, and had reviewed all resident and staff questionnaires that had been conducted to identify any concerns. No concerns had been identified. Record review and interview on 04/23/13 at 1:46 PM with the Clinical Regional Nurse Consultant revealed she had conducted chart audits on

FORM CMS-2567(02-99) Event ID: YL1O11 Previous Versions Obsolete

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| | | | (V2) DATE CUDVEY | |
|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED | |
| AND PLAN OF | IDENNTIFICATION | B. WING | 04/09/2013 | |
| CORRECTION | NUMBER | | | |
| NAME OF PROVIDER OF SUP | 185337 STREET ADDRESS, CITY, STATE, ZIP | | | |
| | EHABILITATION CENTER 246 EAST MAIN STREET | | | |
| BEATTYVILLE, KY 41311 | | | | |
| | ursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0520 | (continued from page 55) 100% of the charts in the facility in an effort to identify potential abuse, which may have been documented but not reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurse Consultant revealed they were conducting ten (10) chart audits a day, seven days a week, to review for signs of abuse that were reported and no concerns were identified. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations | | | |
| E 0520 | allegations to ensure they were in timely to the appropriate State Ag assists in reviewing the abuse inv | | l been reported | |
| 1. 0320 | | | | |
| sasisfs in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action. Based on interview, record review, and review of facility policy and procedures and investigations, it was det facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resided were reported to Facility Administration from 02/17/13 to 04/04/31, involving Residents #1, #4, #19, #29, #3 Interview and record review revealed administrative staff failed to thorough investigate/report these allegations and failed to protect residents. The facility failed to recognize that their established abuse policy for rep abuse was not effective, and freefore failed to implement any corrective actions to correct these problems. (6, F223, F225, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and appropriate plans of action to correct identified deficiencies regarding proting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, residents in the facility. Two Immediate Jeopardy stratorials are serious injury, harm, impairment, or residents in the facility. Two Immediate Jeopardy and 59/24/13 related Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (P223, F225, and F220). The Jacob Practices (P223, F225, and F220, F226, F226) and F226 | | encies and failed to of fresident abuse (#29,#30, and #31. e allegations of y for reporting olems. (Refer to olop and implement e and irment, or death to 3 related to abuse. The Behavior and Facility dard Quality of Care at 42 ted of the Immediate oing. The facility provided al of the Immediate oing. The facility provided al of the Immediate on 04/22-04/23/13, as and Facility Practices (F223 tel the facility develops and rance activities. The s Quality Improvement, and Facility Practices (F223 tel the facility develops and rance activities. The s Quality Improvement, and Facility Practices (F223 tel the facility develops and rance activities. The s Quality Improvement, and Facility Practices (F223 tel the facility develops and rance activities. The solution of the secondary of the secondary of the facility of the secondary of the facility of the faci | | |
| | that occurred from June 2012 thro 04/05/13, the resident stated he/si to three months prior when the inlog was to be maintained by the Aplans of action were effective in i and residents were protected. On #19, #29, #30, and #31 were iden thoroughly investigated. Review addition, an interview with Admireport and investigate allegations #2 was not aware of these allegations coordinator, who was a member revealed she did not have a way to stated there was no way of knowithese allegations. Further interview hith not have a system for tracking/tre held either on 03/13/13 or 03/14/abuse allegations and he was told protected. The Administrator state abuse had not been reported/invested of eyes is all I can say to identif properly trained on how to identif | er, the 03/05/13 AOC stated the facility had reviewed all incidents a bugh the present time, with no concerns. However, during an interviene had reported an allegation of abuse to the facility's social worker cident occurred (03/01/13). In addition, the 04/05/13 AOC stated and instrator to track/trend all allegations of abuse. However, there dentifying allegations of abuse and ensuring all allegations were rep 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse re tiffied which had not been reported to the appropriate State Agencies of the investigation logs revealed no entry related to these allegation instrator #2 revealed the abuse log was not effective to identify facil of abuse and to protect Residents #19, #29, #30, and #31. Per intervious of abuse. An interview on 04/09/13 at 11:99 AM with the Sociof the monthly QA committee and as of 04/08/13 was no longer em to track or a log to review any complaints or allegations related to alt ng what allegations have been made and she was not aware of who werevealed she gave any paperwork she had related to the allegation Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 0 anding abuse allegations. The Administrator further stated that the late. During the meeting, the Administrator further stated that the late of he didn't know why the facility had not identified that other allegatigated and residents had not been protected. The Administrator statify the allegations. An interview on 04/04/13 at 3:15 PM, with the tectors all the proper to the tectors and the proper tested the DON, revealed to Consultant who was filling in at the facility as the DON, revealed to Consultant who was filling in at the facility as the DON, revealed to consultant who was filling in at the facility as the DON, revealed to the consultant who was filling in at the facility as the DON, revealed to the consultant who was filling in at the facility as the DON, revealed the consultant who was filling in at the facility as the DON, revealed the consultant who was fill | ew with Resident #29 on approximately two approximately two a abuse investigation was no evidence these ported/investigated lated to Residents s, and had not been so f abuse. In litiy failures to view, Administrator al Worker/Abuse ployed by the facility, suse. She further was supposed to review is to the 4/04/13 the facility did st QA meeting was o detail about past ints had been ations of resident ted it took a different staff was Chief Nurse Executive | |
| | | t been reviewed through the facility's QA programThe facility p removal of Immediate Jeopardy on 04/17/13 based on the following | | |

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet Page 56 of 59

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF | (X1) PROVIDER / SUPPLIER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|--|
| DEFICIENCIES AND PLAN OF | / CLIA IDENNTIFICATION | A. BUILDING B. WING | 04/09/2013 | |
| CORRECTION | NUMBER 185337 | | | |
| NAME OF PROVIDER OF SUP | AME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP | | | |
| EE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 | | | | |
| For information on the nursing h | * | ey, please contact the nursing home or the state survey agency. | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| | SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM (continued from page 56) the logistic operation of the property of the logistic of the logi | EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY | r for any files related to a reported to be submitted on remoscial Services al Service Director, so Director, Unit Director, Rehabilitation Consultant, Internal Audit conducted 20 interviews re residents feel ms of potential abuse rator, if known, from the will immediately initiate funknown origin. Privice Director, Administrator, the Managers, Assistant tion Manager) or ternal Audit Director, 20 residents daily with a diing any noted changes to the 20 residents views and skin audits nidings of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator. The signs of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator and the signs of signs and will remove the alleged ministrator. The diagnosis of signs and will remove the alleged ministrator to the consultant on 04/12/13 being reviewed by it Manager, Assistant and programs, Chief Nurse this will continue until oleted a review of all reference of signs and signs and signs and signs and signs and signs and will remove the diagnosis of will maintain an entry entry of the diagnosis of the Administrator's or will maintain an entry entry of the Administrator's nor reported, that view on 04/23/13 at 11:32 vith Administrator's nor reported, that with the Chief Nurse twenty (20) skin dentified and spoken to the on 04/23/13 at 1:23 PM with the Director of Service Manager; at the Staff Development a week, of residents wealed the staff had the director of Service Manager; at the Staff Development and the staff had the staff had the staff had the with floor staff daily with entitied medical staff and ducted chart and the director of Service Manager; and at 1:23 PM with the Registered Nurse #5; at 1:41 PM with en wi | |
| | regional ruise Consumant at | 11:32 AM revealed they were reviewing all daily skin assessments | and | |
| | | T TD 405005 | | |

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Page 57 of 59

PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION DEFICIENCIES AND PLAN OF CORRECTION / CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 04/09/2013 185337 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP LEE COUNTY CARE & REHABILITATION CENTER 246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0520 (continued... from page 57) interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interities on 04/25/15 at 2:38 FM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 FM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action. F 0520 Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31. Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F223, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Two Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Fractices (F225, F225, and F226) and F2C9 and F2C9T and F2C9T, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements alleged for Corrections and Pacility the Section 10 of the Section 11 of the Section 10 of the Section 11 of the Section 10 of the Section 10 of the Section 11 of the Sectio implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure entitled Quality Assurance/Continuous Quality Improvement with no date, revealed systems should be in place so that problems were prevented from ever occurring. Further review of the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1. To provide a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and effective systems of services and positive care measures rendered, reinforced, and expanded to improve care given. 2. To establish and provide a system whereby a specific process and the documentation relative to it was maintained to support evidence of an ongoing quality assurance/continuous improvement plan, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to nursing home residents.

3. To develop monitoring tools that provide an effective mechanism to assure that each resident received the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 4. To assist facilities that provided care to residents to delineate lines of authority, responsibility, and accountability so that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility. The policy further stated all corrective activities would be monitored to determine appropriateness and/or the need for alternative measures. According to the policy/procedure, the Administrator of the facility was ultimately responsible for the quality assurance/continuous improvement program and was also responsible for ensuring the quality assurance/continuous improvement program of the facility was in compliance with federal, state, and local regulatory requirements. Based on interview and record review Immediate Jeopardy was identified on 03/01/13 and on 03/29/13 because of the facility's failure to identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition on 04/06/13 and 04/07/13 facility staff was retrained on abuse protocols that included investigation reporting addition, on 04/06/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility had reviewed all incidents and investigations and protection of residents. Futurer, the 0.5/0.5/15 AOC stated the facility had reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these plans of action were effective in identifying allegations of abuse and ensuring all allegations were reported/investigated and residents were protected. On 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In addition, an interview with Administrator #2 revealed the abuse log was not effective to identify facility failures to report and investigate allegations of abuse and to protect Residents #19, #29, #30, and #31. Per interview, Administrator #2 was not aware of these allegations of abuse. An interview on 04/09/13 at 11:09 AM with the Social Worker/Abuse Coordinator, who was a member of the monthly QA committee and as of 04/08/13 was no longer employed by the facility, revealed the did not have a way to track or a lot to review any complaints or allegations of abuse. She further Coordinator, who was a member of the monthiny QA committee and as of 04/08/13 was no longer employed by the facility, revealed she did not have a way to track or a log to review any complaints or allegations related to abuse. She further stated there was no way of knowing what allegations have been made and she was not aware of who was supposed to review these allegations. Further interview revealed she gave any paperwork she had related to the allegations to the Administrator. An interview with Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been protected. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse held not been reported/investigated and residents it took a different protected. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse had not been reported/investigated and residents had not been protected. The Administrator stated it took a different set of eyes is all I can say to identify the allegations. The Administrator further stated he did not feel staff was properly trained on how to identify abuse allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as part of the facility's AOCs had not been reviewed through the facility's QA program. ---The facility provided an acceptable AOC on 04/17/13, which alleged removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. Administrator #1, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185337 If continuation sheet Previous Versions Obsolete Page 58 of 59

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED:3/30/2014 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION) CLIA IDENNTIFICATION A. BUILDING B. WING 04/09/2013 NUMBER 185337

NAME OF PROVIDER OF SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP

246 EAST MAIN STREET BEATTYVILLE, KY 41311 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAC

LEE COUNTY CARE & REHABILITATION CENTER

F 0520

(continued... from page 58)
will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Chebabilitation Manager) or Regional staff (Clinical Program Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) will visit 20 residents daily with a BIMS score of less than 7 and will speak to the Nurse and CRA (State Registered Nurse will visit 20 residents with BIMS score of less than 7, to ensure that no physical signs of abuse are present. The above interviews and skin audits will be placed in a binder called the AOC binder that will be located in the Administrator's office. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator of abuse or injuries of unknown origin. The Administrator, Director of Nursing, Social Services Director, or Regional Staff will review all resident and staff questionnaires daily for grievances/concerns. Investigations of grievances/concerns will be initiated upon identification. All resident records were reviewed by the Clinical Regional investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy.—Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Reabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting twenty (20) interviews daily, seven (7) days a week, of residents with a BIMS of seven (7) or higher related to abuse/neglect. Further interviews and record review revealed the staff had also visited with twenty (20) residents a day, seven (7) days a week, who had a BIMS below seven (7), and had spoken to the Nurse and SRNA regarding any changes in behaviors or signs of abuse. Record review and interview on 04/23/13 at 1:23 PM with the Staff Development Coordinator; at 11:32 AM with the Regional Nurse Consultant; at 11:53 with the Chief Nurse Executive; and at 12:21 PM with the Director of Nursing revealed they had assisted with conducting twenty (20) skin assessmen Executive, and at 12:21 FM with the Director of Nursing leveled they had assisted with conducting twenty (20) skin assessments a day, seven (7) days a week, of the residents that were non-interviewable and had not identified any concerns related to physical abuse. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting interviews with twenty (20) staff members a day, seven (7) days a week, regarding their knowledge of the facility's policy on abuse/potential abuse.

Interview on 04/23/13 at 10:35 AM with SRNA #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:30 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #12; at 12:25 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 12:17 PM with Maintenance Worker #1; at 1:41 PM with Laurder Worker #1; at 1:45 PM with Activity Accident #1; at 1:40 PM with Accident #1; at 1:40 PM with Laurder Worker #1; at 1:41 PM with Laurder Worker #1; Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 revealed management staff had spoken with floor staff daily regarding their knowledge of the facility's policy on abuse and if they were aware of any potential abuse situations in the facility. Interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they had met daily, seven days a week, and had reviewed all resident and staff questionnaires that had been conducted to identify any concerns. No concerns had been identified. Record review and interview on 04/23/13 at 1:46 PM with the Clinical Regional Nurse Consultant revealed she had conducted chart audits on 100% of the charts in the facility in an effort to identify potential abuse, which may have been documented but not reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurse PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurs Consultant revealed they were conducting ten (10) chart audits a day, seven days a week, to review for signs of abuse that were reported and no concerns were identified. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis.

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185337 If continuation sheet Page 59 of 59