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Governor

**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF THE INSPECTOR GENERAL**

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TYPE "A" CITATION

April 10, 2009

Bluegrass Care and Rehabilitation Center
3576 Pimlico Parkway
Lexington, KY 40517

ADMINISTRATOR: JoAnn Lovall

This citation is issued pursuant to KRS 216.555 and KRS 216.557 and 900 KAR 2:040 Section 2 for violations of 902 KAR 20:300 Section 5(3). This citation may be appealed according to the provisions of 900 KAR 2:020, which state that a written request of hearing must be made to the Secretary of the Cabinet for Health and Family Services within twenty (20) days of the receipt of the written notice of the action. Any penalty assessed for this citation may be appealed under the same provisions.

Based on the findings of an abbreviated survey initiated 03/23/09, it was determined the facility failed to protect residents from abuse for seven residents (Resident #1, #2, #3, #4, #9, #11, and #12). The facility failed to follow their "Prevention of Abuse, Neglect, and Misappropriation of Resident's Property" policy as evidenced by failing to ensure that staff were knowledgeable in identifying incidents as abuse and appropriately reporting allegations; and failing to conduct a thorough investigation of abuse allegations. Per interview with facility staff, staff utilized their personal cell phones to inappropriately photograph and/or make audio recordings of facility residents without the residents'



expressed permission or knowledge. Interviews with facility staff, including aides, licensed staff and housekeepers revealed this was a usual event that was not recognized or identified as abuse; therefore staff failed to report the abuse to their supervisors. After the facility became aware of this situation the facility failed to conduct a thorough investigation. The facility failed to conduct interviews of all residents and staff that were involved. Additionally, there was no evidence the facility had identified or trained staff that using residents' pictures and/or recordings of a sexually exploitative nature were a form of abuse. Furthermore, interviews with licensed staff revealed the facility was not enforcing its policy that staff was not to have cell phones in resident care areas.

The facility failed to have an effective system in place to ensure residents were protected from abuse. The facility's failure placed residents in imminent danger and at substantial risk of serious harm. The facility was notified of the imminent danger on 04/08/09.

ISSUED BY: Brenda Zehm

RECEIVED BY: [Signature]

TITLE: Dietetic Inspector

TITLE: Administrator

DATE: 04/10/09

DATE: 4-10-09

WITNESS: [Signature] SDC

DATE TO BE CORRECTED: IMMEDIATELY (04/10/09)

CORRECTED DATE: _____

VERIFIED CORRECTED DATE: _____