

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

PRINTED: 06/28/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/14/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056
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F 000	INITIAL COMMENTS An abbreviated survey (KY #18470) was conducted on 06/13/12 and concluded on 06/14/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the Federal requirements for recertification with deficiencies cited. KY #18470 was unsubstantiated with a related deficiency cited, and an unrelated deficiency cited, at the highest scope and severity of a "D".	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, and review of the facility's policy and procedure, it was determined the facility failed to ensure the policy and procedure was implemented that prohibited the mistreatment, neglect, and abuse of residents for one resident (#1), in the selected sample of four residents. On 05/24/12, it was reported to the Social Service Director (SSD) that Certified Nurse Aide (CNA) #1 pushed Resident #1 down into his/her wheelchair. CNA #1 was instructed by the SSD to go to the front of the building and report the allegation to the Director of Nursing (DON). CNA #1 walked through the facility unsupervised from the back of the facility to the front of the facility through resident care areas. The SSD stayed with Resident #1 while CNA #1, who was	F 226	F 226 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. Resident(s) affected by alleged deficient practice: • Resident #1 was found to have no injury associated with the alleged incident. 2. Residents with potential to be affected by alleged deficient practice: • All residents have the right to be free from willful physical and emotional abuse. No residents were found to have any indications of abuse/neglect as a result of the accused aide being allowed to walk through the facility unescorted. Note: the nurse aide was not suspended until 2 days after the allegation, however, she did not work between 5/24/12 and 05/26/12, at which time she was suspended until the investigation was complete.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dinger Atkins</i>	TITLE Executive Director	(X6) DATE 07-03-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>accused of physical abuse, was allowed to walk through the facility unsupervised to report the allegation to the DON. The facility failed to protect the other residents in the facility by not escorting CNA #1 to the DON's office and by not suspending the CNA #1 until two days later, on 05/26/12.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Protection of Residents: Reducing the Threat of Abuse & Neglect" (revised 02/09), revealed all residents have the right to be free from willful physical and emotional injury, punishment, intimidation, or unreasonable confinement. Residents must not be subjected to abuse by anyone. If the accused individual is an employee, they will be placed on suspension pending results of the investigation while the incident is being investigated. The person observing an incident of resident abuse or suspecting resident abuse will immediately report such incidents to their immediate supervisor and or charge nurse.</p> <p>A record review revealed Resident #1 was admitted to the facility on 04/10/12 with diagnoses to include Anxiety, Depression and Paraplegia. A review of an admission Minimum Data Set (MDS), dated 04/20/12, revealed Resident #1 was assessed as moderately cognitively impaired.</p> <p>A review of the facility's investigation, dated 05/29/12, revealed Resident #1, on 05/24/12, came out into the hallway and reported to the SSD that "I don't want her (CNA #1) back in my room. She (CNA #1) pushed me down in my</p>	F 226	<p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> Administrator provided education to Social Services Director and Director of Nursing on July 2, 2012, in regard to facility policy of protection of residents from abuse and neglect. Training specifically focused on timely reporting of allegations of abuse and neglect as well as protection of all residents from alleged abusive staff. Administrator provided the following education: Beginning 07/10/2012, staff inserviced on facility policy and procedures related to reporting and investigation of allegations of abuse and neglect. Education to include providing for the safety of all residents, reporting of allegations, and initiating investigations. Education will be provided until all staff educated. Upon any reports of allegation of abuse or neglect, Administrator or designee will immediately initiate safety measure for any resident involved as well as an investigation of the allegation. Staff involved in any allegation of abuse/neglect will be escorted from resident care areas, suspended pending investigation results. All noted education will be completed at General Orientation, quarterly, and as needed. 		

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F 226	<p>Continued From page 2</p> <p>wheelchair." The SSD then instructed CNA #1 (the alleged perpetrator), to go report the allegation to the DON, while the SSD stayed with Resident #1. Further review revealed, on 05/26/12, Resident #1 told Registered Nurse (RN) #1 that he/she was physically abused on 05/24/12 by CNA #1. Resident #1 reported to RN #1 that CNA #1 pushed him/her down into his/her wheelchair while providing care to him/her. RN #1 then informed the DON about the allegation of physical abuse on 05/26/12, which occurred on 05/24/12. CNA #1 was suspended on 05/26/12.</p> <p>An interview with CNA #1, on 04/16/12 at 10:00 AM, revealed she was was instructed by the SSD to walk to the front of the facility and report the allegation of physical abuse to the DON, on 05/24/12. She further stated she walked to the front of the building unescorted through resident care areas and was not suspended until 05/26/12.</p> <p>An interview with CNA #2, on 06/14/12 at 1:45 AM, revealed CNA #1 was instructed, on 05/24/12, to walk to the front of the building to find the DON to tell her that she (CNA #1) was accused of physical abuse by a resident. CNA #1 was unescorted during her walk through the facility to include resident care areas.</p> <p>An interview with the SSD, on 06/14/12 at 10:35 AM, revealed she told CNA #1, on 05/24/12, to walk to the front of the building and report the allegation of physical abuse to the DON. The SSD further stated she was not following the facility's abuse/neglect policy when she allowed CNA #1 to walk to the front of the facility unescorted. She did not know why CNA #1 was</p>	F 226	<p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • 24 hour report sheets and incident reports will be reviewed daily by Administrative team, Monday-Friday, and by Nurse Unit Manager on Saturday-Sunday. Administrator or designee will be responsible to ensure procedures are implemented for timely reporting of any allegations of abuse, as well as the implementation of safety measures for protection of all residents. • Results of all investigations will be reported to Regional Vice President or Regional Director of Clinical Services to ensure policy and procedure was followed and a thorough investigation has been completed. • Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	07-13-12

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F 226	Continued From page 3 not suspended until 05/26/12., two days after the allegation was made. An interview with the Administrator, on 06/14/12 at 11:30 AM, revealed her understanding was that the allegation of abuse was first reported on 05/26/12, and therefore, CNA #1 was not suspended until that date, although the investigation revealed the SSD was told by the resident that CNA #1 physically abused him/her on 05/24/12. The Administrator further stated that CNA #1 should have been escorted by staff to the DON's office after the allegation of physical abuse was made instead of being allowed to walk through the facility alone. It was possible that CNA #1 could have abused other residents during her walk through the facility.	F 226	F 246 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered. 1. Resident(s) affected by alleged deficient practice. <ul style="list-style-type: none"> Resident #4 had water pitcher placed at bedside and within reach. 2. Residents with potential to be affected by alleged deficient practice. <ul style="list-style-type: none"> 100% audit completed by Nursing Management on 06/29/12-07/02/12. Audit done to ensure all residents had water pitchers available and within reach, unless otherwise indicated. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> DON or Staff Development Coordinator initiated education on 07/02/2012 to nursing staff on ensuring residents have water pitchers within reach as appropriate. Education will continue until all staff educated. 		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#4), in the selected sample of four residents, who was non-ambulatory and coded as requiring assistance to eat/drink, had his/her water pitcher within reach during four	F 246			

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F 246	<p>Continued From page 4</p> <p>observations on two consecutive days of the complaint investigation.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Hydration & Nutrition," (revised 10/08), revealed the nutrition and hydration status of each resident is maintained as close to optimal level as possible. Ensure fluids are available to residents at all times.</p> <p>A record review revealed the facility admitted Resident #4 on 03/05/09 with diagnoses to include Senile Dementia, Osteoarthritis, CVA with left Hemiparesis. A review of the annual Minimum Data Set (MDS), dated 12/14/11, revealed the resident was severely cognitively impaired and was coded to need one person physical assistance for eating and drinking, and required a two person physical assist for all transfers.</p> <p>A review of the resident's care plan, dated 05/25/12, revealed the resident had potential for fluid changes related to receiving a diuretic, and the intervention was to "provide the resident with adequate fluids." A review of the Certified Nurse Aide (CNA) care plan, dated 06/14/12, revealed the resident required much encouragement for all activities and activities of daily living, and to use simple direct cues.</p> <p>Observation, on 06/13/12 at 5:00 PM, revealed Resident #4 was lying in bed and the resident's water pitcher was on a built-in counter directly across the room from his/her bed, out of his/her reach. Further observations, on 06/14/12 at 8:15</p>	F 246	<p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> DON or designee will audit 5 residents daily, Monday thru Friday, x 2 weeks; 15 residents weekly x 4 weeks, then monthly x 3 months, to ensure fluids are within reach. Nursing Administration will provide on-going education as indicated for non-compliance. Results of audits will be brought to the monthly Performance Improvement committee to determine the need for further monitoring and updated the plan as needed. Appropriate actions plans will be reviewed and revised as needed. 	07-13-12	

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F 246	<p>Continued From page 5</p> <p>AM, 10:28 AM, and 11:55 AM, revealed the resident's water pitcher was in the same location on a built-in counter across the room, which was out of the resident's reach.</p> <p>Interview with CNA #2, on 06/14/12 at 1:45 PM, revealed Resident #4 was non-ambulatory and should have his/her fluids in reach at all times. He/she cannot reach fluids if the water pitcher was sitting on the cabinet counter across the room.</p> <p>Interview with Registered Nurse (RN) #1, on 06/14/12 at 1:38 PM, revealed Resident #4 was nonambulatory and must have his/her fluids in reach at all times. She expected the CNAs to keep the resident's water pitcher in reach at all times, and not to place it on the cabinet counter across the room from his/her bed where he/she could not reach it.</p>	F 246			