

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

PRINTED: 08/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2010
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 833 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement its written policies and procedures related to the allegation of the abuse for one (1) of three (3) sampled residents (Resident #1). On 07/20/10, Resident #1 informed facility staff and his/her daughter of an allegation of abuse, stating he/she was raped "by two boys". However, the facility did not initiate an investigation, until 07/21/10, when the resident's family asked about the investigation.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed the resident was admitted on 08/01/07, with diagnoses which included Hypertension, Alzheimer's Disease, Dementia, Depression, and Unspecified Non Organic Psychosis. Review of the Minimum Data Set (MDS), dated 06/30/10</p>	F 226	<p>This prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law require it.</p>	

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- BY: _____
- The Assistant Director of Nursing counseled employee #1 on 7/21/2010 regarding proper reported of suspected abuse according to the facilities Abuse policy.
 - Social Services Director conducted interviews with other residents. No issues were identified. The DON and designees, performed assessments on all other residents on south wing. No other issues were identified.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 9/2/10
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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>revealed the facility assessed Resident #1 to have short term and long term memory deficit and to be moderately impaired in cognitive skills for daily decision making.</p> <p>Review of the History and Physical Report, dated 07/14/10 revealed the facility assessed the resident as exhibiting psychological symptoms including agitation, anxiety, confabulation, and disorientation, which have occurred in a persistent pattern for years.</p> <p>Interview on 07/30/10 at 12:15 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #1 told her on 07/20/10 that he/she was raped "by two boys". LPN #1 stated she did not report the allegation because she did not believe the resident had been raped. Further interview revealed the resident's Daughter #2 was at the facility on 07/20/10 and the resident had also told her of the alleged rape. Further interview revealed LPN #1 discussed the rape allegation with Daughter #1, who attributed the allegation to a recent adjustment of the resident's medications. His/her Ativan was discontinued and the Zyprexa dose was increased to twice a day.</p> <p>Interview on 07/30/10 at 10:15 AM, with the facility's Social Worker revealed he had received a call from Resident #1's Power of Attorney (POA) on 07/21/10, notifying him of Resident #1's allegation of rape. Further interview revealed he immediately called the Assistant Director of Nurses (ADON) and the Administrator, who instructed him to start an investigation of the allegation. Further interview revealed the Social Worker and the ADON interviewed all employees involved, and suspended the alleged perpetrator, Certified Nursing Assistant (CNA) #2, on that</p>	F 226	<ol style="list-style-type: none"> 3. An inservice was initiated on 7/21/2010 by the ADON and the SDC for all staff, regarding the facilities policy on abuse reporting. All staff will be required to attend this inservice by 9/10/2010. Anyone not completing the inservice by 9/10/2010 will be required to do so prior to the next scheduled day of work. 4. Random staff interviews will be conducted weekly times four weeks then monthly times three months to insure staff's knowledge of the facilities abuse reporting policy. Any issues revealed from these interviews will be addressed accordingly and brought before the monthly Performance Improvement committee for review and to discuss any further actions needed. 5. Date of Compliance: 9/13/2010 	
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F 226	<p>Continued From page 2</p> <p>date. During further interview, the Social Worker indicated LPN #1 should have reported the allegation to Administration immediately.</p> <p>Interview on 07/30/10 at 12:35 PM, with the Administrator revealed he was informed of the allegation on 07/21/10 and gave instructions to start an investigation immediately. Further interview revealed LPN #1 should have reported the alleged rape to administration, even if she did not believe the rape had happened.</p> <p>On 07/30/10 at 12:40 PM, interview with the DON revealed LPN #1 should have reported the rape allegation, even if she did not believe it occurred.</p> <p>Review of the facility's policy on Reporting and Prevention of Abuse revealed: All allegations of abuse must be taken seriously, even if the resident is confused and tells more than one story or can't remember the details; allegations of abuse must be reported to the supervisor and POA immediately.</p> <p>Review of LPN #1's Inservice Record for Reporting and Prevention of Abuse dated 04/09/10, revealed she had attended and demonstrated competence in her knowledge of the proper procedure regarding this aspect of resident care.</p>	F 226			